

Arizona Department of Administration
Human Resources Division - Benefit Services

2014 Retired State Employees Benefit Guide



In This Guide:

- Benefit Changes
- Benefit Eligibility
- Medical & Prescription Benefits
- Medicare
- Dental Benefits
- Vision Benefits
- Addendum - Medicare Prescription Drug Plan Documents



CONTACTS

ADOA Contacts

Human Resources Division -
Benefit Services

100 N. 15th Ave #103

Phoenix, AZ 85007

602.542.5008 or

1.800.304.3687

Fax 602.542.4744

www.benefitoptions.az.gov

BenefitsIssues@azdoa.gov

Benefit Options Wellness

602.771.9355

www.benefitoptions.az.gov/wellness

Medical Plans

Aetna

1.866.217.1953

www.aetna.com

Policy Number 476687

Blue Cross Blue Shield
of Arizona network
administered by AmeriBen

1.866.955.1551

www.myameriben.com

Policy Number 1009013

Cigna

1.800.968.7366

www.cigna.com/stateofaz

Policy Number 3331993

UnitedHealthcare

1.800.896.1067

www.myuhc.com

Policy Number 705963

Pharmacy Plan

MedImpact

1.888.648.6769

www.benefitoptions.az.gov

ADOAcustomerservice@

medimpact.com

Medicare GenerationRx-

Employer PDP

(for Medicare eligible retirees
& dependents)

1.877.633.7943

[medicaregenerationrx.com/](http://medicaregenerationrx.com/stateofaz)

stateofaz

Dental Plans

Delta Dental of Arizona

602.588.3620

1.866.9STATE9

www.deltadentalaz.com

Policy Number 77777-0000

Total Dental Administrators
Health Plans, Inc. (TDAHP)

602.381.4280

1.866.921.7687

www.TDA dental.com/adoa

Policy Number 680100

Vision Plan

Avesis, Inc.

1.888.759.9772

www.avesis.com

Advantage

Policy Number 10790-2075

Plan Number 938AZ

Discount Policy Number

10000-5

Plan Number 9000

Long-Term

Disability Plans

Sedgwick CMS

(ASRS participants)

1.800.495.9301

[www.sedgwickcms.com/](http://www.sedgwickcms.com/calabasas)

[calabasas](http://www.sedgwickcms.com/calabasas)

The Hartford

(PSPRS, EORP, CORP, and
ORP, retirement participants)

1.866.712.3443

[http://groupbenefits.](http://groupbenefits.thehartford.com/arizona/)

[thehartford.com/arizona/](http://groupbenefits.thehartford.com/arizona/)

Policy Number 395211

Retirement Systems

Arizona State Retirement

System (ASRS)

3300 N. Central Ave, Lobby

Phoenix, AZ 85012

602.240.2000 or

1.800.621.3778

www.azasrs.gov

Public Safety Personnel

Retirement System (PSPRS);

Elected Officials' Retirement

plan (EORP); Corrections

Officer Retirement Plan

(CORP)

3010 E. Camelback Rd, #200

Phoenix, AZ 85016

602.255.5575

1.877.925.5575

www.psprs.com



TABLE OF CONTENTS

Welcome to the 2014 Retired Employee Benefit Guide!

This guide describes the benefits offered by the State of Arizona, Department of Administration, Human Resources Division, Benefit Services comprehensive benefits package “Benefit Options” effective January 1, 2014. Included in this reference guide, are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This guide is intended to help you understand your benefits.

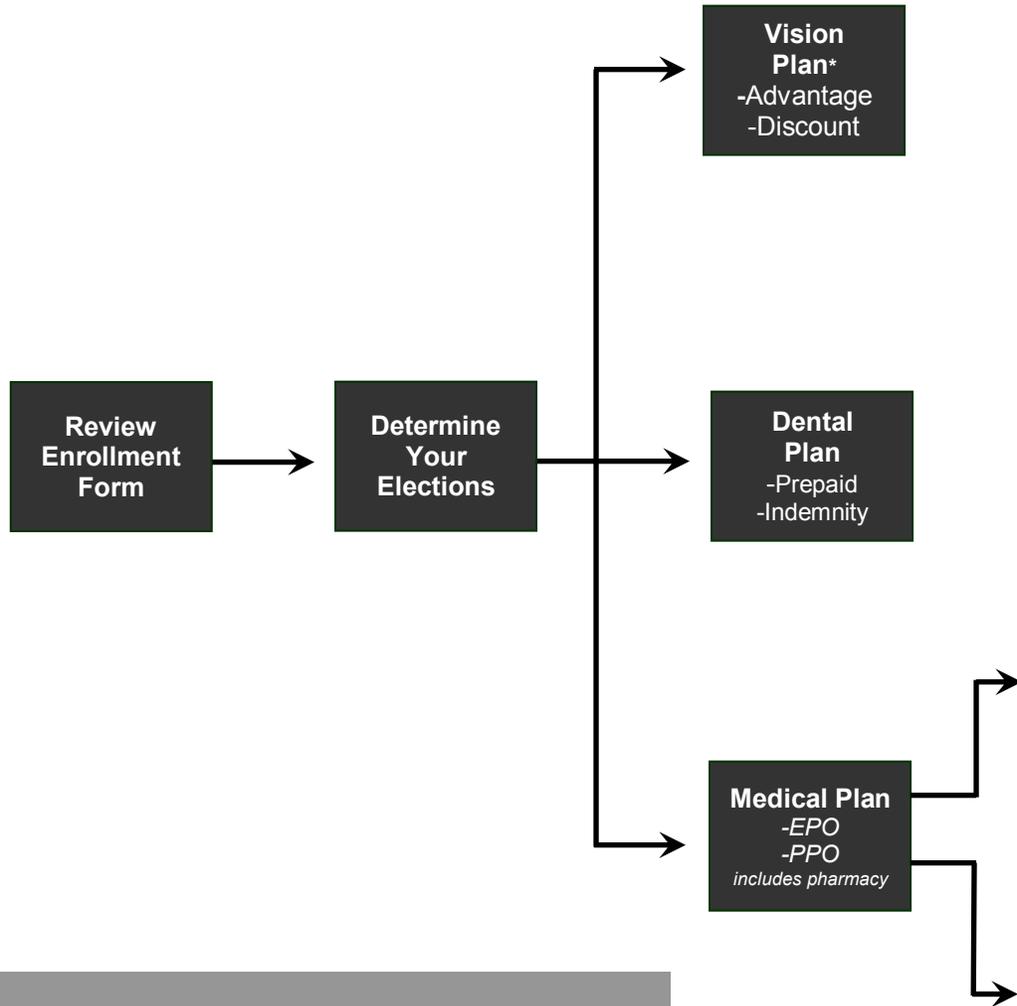
The guide is divided into chapters, each covering a specific benefits program or important information. We encourage you to review each section before making your benefit elections. For more information, please refer to your plan descriptions. If you need additional information, please visit our website at benefitoptions.az.gov or call us at 602.542.5008 or toll free at 1.800.304.3687.

Retiree Enrollment At-A-Glance	1-2	Medicare Eligible Pharmacy Plan Information	36-41
Benefits Changes for Plan Year 2014	3	Medicare Eligible Pharmacy Online Features	42
Eligibility	4-7	Dental Plan Information	43
Changing your Benefits	8-9	Dental Online Features	44
Summary of Monthly Insurance Premiums	10-11	Dental Plans Comparison Chart	45
Understanding your Insurance Cost	12-15	Vision Plan Information	46
Medicare Part A & B	16-18	Vision Online Features	47
Medicare Part D	19	Vision Plans Comparison Chart	48-49
Medical Plan Information	20-21	International Coverage	50
Medical Online Features	22-25	Long-Term Disability Members	51
Medical Plans Comparison Chart	26	Legal Notices	52
Medical Management	27-28	Glossary	53-57
Network Options Outside of Arizona	29	Addendum - Medicare Prescription Drug Plan Documents	58
Pre-Medicare Pharmacy Plan Information	30-33		
Pre-Medicare Pharmacy Online Features	34		
Pre-Medicare Pharmacy Benefits Summary	35		

This Benefit Options guide is designed to provide an overview of benefits offered through the State of Arizona Benefit Options Program. The actual benefits available to you and the descriptions of these benefits are governed in all cases by the relevant Plan Descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefits plans at anytime.



2014 RETIREE



Learn more...

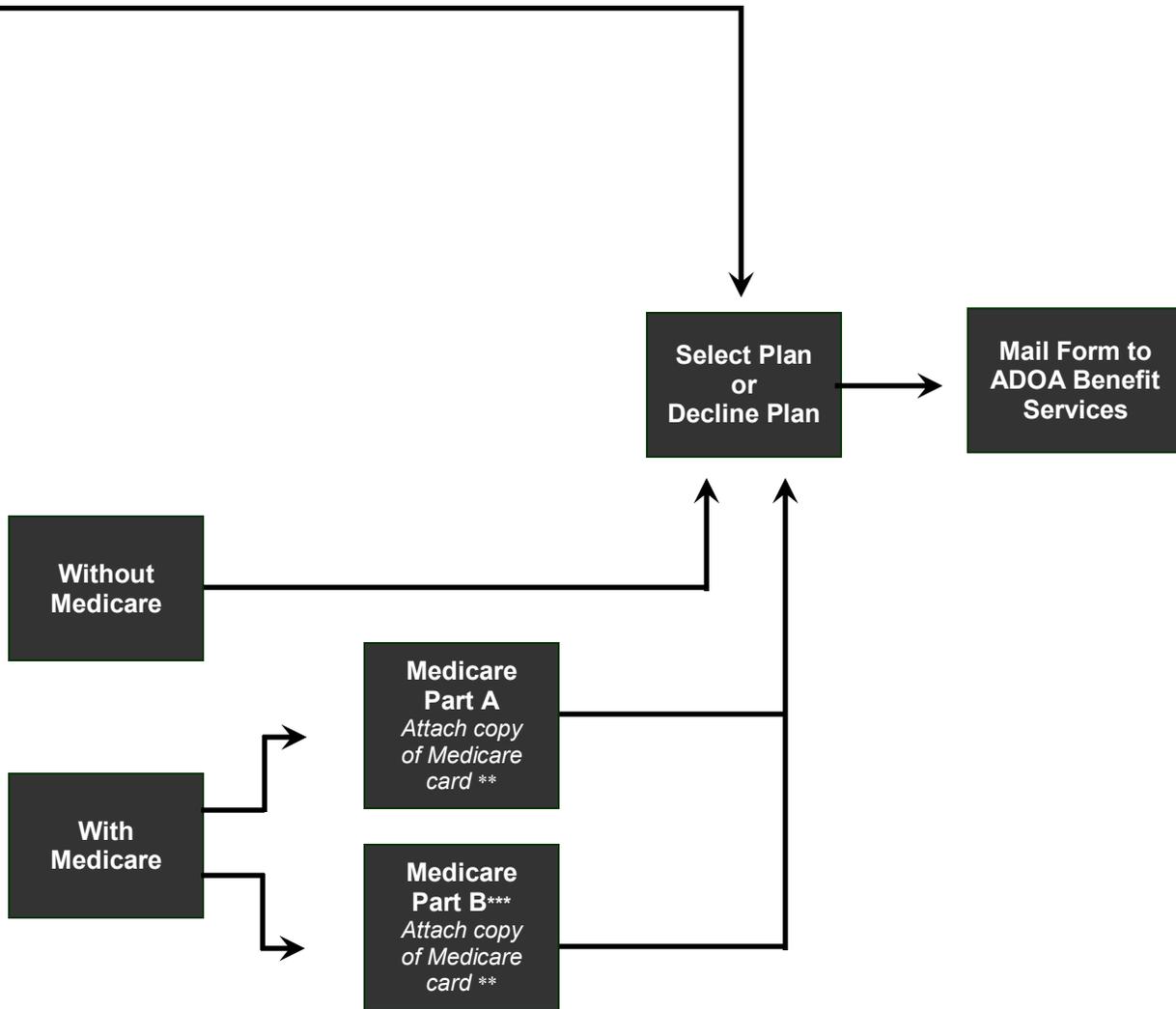
	Page
Medical Plan Information	20
Pre-Medicare Pharmacy Plan Information	30
Medicare Eligible Pharmacy Plan Information	36
Dental Plan Information	43
Vision Plan Information	46

**Only available if medical and/or dental coverage is selected.*

***Medicare card required if electing a Medicare Plan with ADOA.*

****If you are eligible for Medicare Part B and choose not to elect it, you will be responsible for the cost of services covered by Medicare Part B.*

ENROLLMENT AT-A-GLANCE



Submit Medicare GenerationRx application form for each Medicare eligible family member electing medical coverage.



BENEFITS CHANGES FOR PLAN YEAR 2014

Medical Plan Changes

Residential Substance Abuse

The 90 visit limitation for Residential Substance Abuse will be removed. In addition, all mental health diagnoses will be eligible to be covered in a residential treatment setting.

Laparoscopic Sleeve Gastrectomy

The medical plan will now provide coverage for Laparoscopic Sleeve Gastrectomy.

Pharmacy

Employer Group Waiver Program

Effective January 1, 2014, all Medicare eligible participants covered under the State of Arizona Benefit Options Program will be enrolled in a Medicare Prescription Drug Plan (PDP). A prescription drug plan that combines a standard Medicare Part D plan with additional prescription drug coverage provided by Benefit Options. The plan name is Medicare GenerationRx (Employer PDP). The program is sponsored by Stonebridge Life Insurance Company, a Medicare approved Part D sponsor, and administered by MedGenerations. We refer to this program as **Medicare GenerationRx for Benefit Options**. This change will result in a separate prescription plan for Medicare eligible retirees and their Medicare eligible dependents. The changes will be implemented with limited member disruption.

Dental Plan Changes

Delta Dental PPO plus Premier (self funded)

The six (6) month waiting period will be removed for all Class III benefits which

include:

- crowns
- onlays
- bridges
- partial/complete dentures
- bridge/denture repair
- orthodontic
- and implants services

The reimbursement period for orthodontics will be extended from six (6) months to twelve (12) months.

The change will result in one payment upon insertion/banding of the appliance and a second payment issued at twelve (12) months if the member is still eligible for benefits under the plan.

Notice about the Summary of Benefit and Coverage (SBC) and Uniform Glossary

On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary. The SBCs documents along with the uniform glossary will be posted electronically to the Benefit Options Website benefitoptions.az.gov. You may also contact Benefit Services to obtain a copy.



ELIGIBILITY

Domestic Partners

Pursuant to a change in Arizona law, A.R.S. § 38-651(O), domestic partners are not eligible dependents under the State of Arizona's benefit plan. As a result, this Arizona law precludes previously qualified same-sex and opposite-sex domestic partners from receiving benefits that were created by administrative rulemaking in Arizona Administrative Code § R2-5-101(22).

Accordingly, the State of Arizona will not be offering benefits to opposite-sex domestic partners.

The State of Arizona intended that this law apply equally to same-sex domestic partners. However, a United States Federal District Court, in *Diaz v. Brewer, et al.* (2:09-cv-02402 JWS), imposed a preliminary injunction preventing the State of Arizona from implementing A.R.S. § 38-651 (O) as applied to qualified same-sex domestic partners. The case is still in litigation and the State intends to defend its right to fully implement the statute and discontinue offering benefits to all domestic partners.

Important Disclosure and Disclaimer to Qualified Same-Sex-Domestic Partners:

As a result of the U.S. District Court preliminary injunction, the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are herein **ADVISED and CAUTIONED** that the preliminary injunction possibly could be lifted after open enrollment

or during the 2014 Plan Year. If that were to occur, the State of Arizona would no longer be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to same-sex domestic partners during the 2014 Plan Year and thereafter. This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan.

Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future.

Eligible Retirees

The following persons are eligible to participate in the Arizona Benefit Options program:

- A. Retirees receiving a pension under a state-sponsored retirement plan and continuing enrollment in the Retiree health and/or dental plan.
- B. Long-Term Disability (LTD) participants collecting benefits under a state-sponsored plan.
- C. Eligible former elected officials and their qualified dependents if the elected official has at least 5 years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.



ELIGIBILITY Continued

- D. Surviving spouses and qualified dependents provided they were covered at the time of the retiree's death.
- E. Surviving spouses of former elected officials provided they were covered at the time of the official's death.

Eligibility Rules

- A. As an eligible retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).
- B. If you have declined or cancelled ADOA's medical and/or dental coverages in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverages during an Open Enrollment period.
- C. If you have a qualified dependent that is not currently enrolled in Arizona Benefit Options, he or she may be added during an Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment unless there is a Qualified Life Event (QLE). You have 31 days from the QLE to change your enrollment through ADOA, Human Resources Division, Benefit Services. The change must be consistent with the event. Please refer to the Benefit Services website for more information about QLEs.

Eligible Dependents

At Open Enrollment, you may add the following dependents to your plans (proper documentation may be required):

- A. Your legal spouse
- B. Your same-sex domestic partner subject

to the following qualifications and proper documentation:

- a. Shares the employee's or retiree's permanent residence;
- b. Has resided with the employee or retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at the time of enrollment;
- c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;

Important Disclosure and Disclaimer:

The State of Arizona is not offering benefits to opposite-sex domestic partners. As a result of the U.S. District Court preliminary injunction (described in detail on page 4 in the "Eligibility" section of this manual), the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 2014 Plan Year. If that were to occur, the State of Arizona would no longer be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to qualified same-sex domestic partners during the 2014 Plan Year and thereafter. This also would include



ELIGIBILITY Continued

dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan. **Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future.**

- d. Does not have any other domestic partner or spouse of the same or opposite sex;
- e. Is not legally married to anyone or legally separated from anyone else;
- f. Is not a blood relative any closer than would prohibit marriage in Arizona;
- g. Was mentally competent to consent to the contract when the domestic partnership began;
- h. Is not acting under fraud or duress in accepting benefits;
- i. Is at least 18 years of age; and
- j. Is financially interdependent with the employee or retiree in at least three of the following ways:
 - i. Having joint mortgage; joint property tax identification, or joint tenancy on a residential lease;
 - ii. Holding one or more credit or bank accounts jointly, such as a checking account, in both names;
 - iii. Assuming joint liabilities;
 - iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
 - v. Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or

employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; and

- vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or
- vii. Other proof of financial interdependence as approved by the Director.

C. Your child defined as:

- a. Your or your qualified same-sex domestic partner's natural, adopted and/or stepchild who is under 26 years old;
- b. A person under the age of 26 for whom you or your same-sex domestic partner have court-ordered guardianship;
- c. Your or your same-sex domestic partner's foster children under the age of 26;
- d. A child placed in your home by court order pending adoption;
- e. Your or your same-sex domestic partner's natural, adopted and/or stepchild:
 - i. Who was disabled as defined by 42 U.S.C. 1382c before the age of 26;
 - ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;
 - iii. Who is dependent for support and maintenance upon you or your same-sex domestic partner;
 - iv. For whom you or your same-sex domestic partner had custody before the child was 26.



ELIGIBILITY Continued

Dependent Documentation Requirements

If your dependent child is approaching age 26 and is disabled, application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, that occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

Qualified Medical Child Support Order (QMCSO)

You may not terminate coverage for a dependent covered by a QMCSO.

If You and Your Spouse are both State Retirees

You cannot enroll as a single subscriber and be enrolled as a dependent on your spouse's policy simultaneously. If you do enroll in this manner, no refunds will be made for the premiums paid.

Eligibility Audit

Benefit Services may audit a member's documentation to determine whether an enrolled dependent is eligible according to the plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility. Should you have questions after receiving a request to provide proof of dependent eligibility, please contact the Audit Services Unit within Human Resources Division, Benefit Services.

Subrogation

Subrogation is the right of an insurer to recover all amounts paid out on behalf of you,

The insured. In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options has the legal right to recover against the party responsible for your illness or injury or from any settlement or court judgment you may receive, up to the amount of benefits paid out by Benefit Options. As a Benefit Options member you are required to cooperate with the vendors acting on behalf of ADOA during subrogation process. Failure to do so may result in legal action by the State to recover funds received by you.

Return to Work Retirees

Former retired State employees returning to Active State Employment can receive health benefits through the Benefit Options Health Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving state service is considered a Qualified Life Event (QLE). The QLE then allows them to enroll in retiree benefits again.

End-Stage Renal Disease

If you are eligible to enroll in Medicare as an active employee or retiree because of End-Stage Renal Disease, the plan will pay for the first 30 months, whether or not you are enrolled in Medicare and have a Medicare card. At the end of the 30 months, Medicare becomes the primary payer. If a plan member who is eligible for Medicare Part B does not enroll in Medicare Part B, the plan will only pay secondary benefits after 30 months of primary coverage.



CHANGING YOUR BENEFITS

You may only change your benefit elections when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next open enrollment period to make benefit changes.

Qualifying Life Events

Events that may be considered include but are not limited to:

- A. Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse;
- B. Changes in dependent status: birth adoption, placement for adoption, guardianship, death, or dependent eligibility due to age.
- C. Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependent.

Submitting a Change Request

Requested benefit changes must be submitted in writing to ADOA Human Resources Division, Benefit Services within 31 calendar days of the event.

Effective Date of the Change

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event.

The effective date for benefit changes based on all other QLEs is the first day of the next calendar month, following the date the retiree submits the requested change, in writing, to ADOA Human Resources Division, Benefit Services.

Please consult with ADOA Human Resources Division, Benefit Services to determine whether or not the life event you are experiencing qualifies under the regulations.

Premium Changes Due to QLEs

Any change in premiums due to a QLE will be in effect the first of the month following the receipt of all QLE documentation.

Refer to the flow chart on the following page for help in determining the effective dates of qualified life events.

New Retiree's Option of Life Insurance Continuation

As a new retiring State of Arizona employee, you have the option of continuing all or a portion of your Life Insurance coverage with the Hartford. There are two options for continuation of coverage:

- Converting your group Life coverage to your own individual policy.
- Porting your Life coverage which continues as a term life policy. To be eligible for portability, you must terminate employment prior to Social Security Normal Retirement Age.

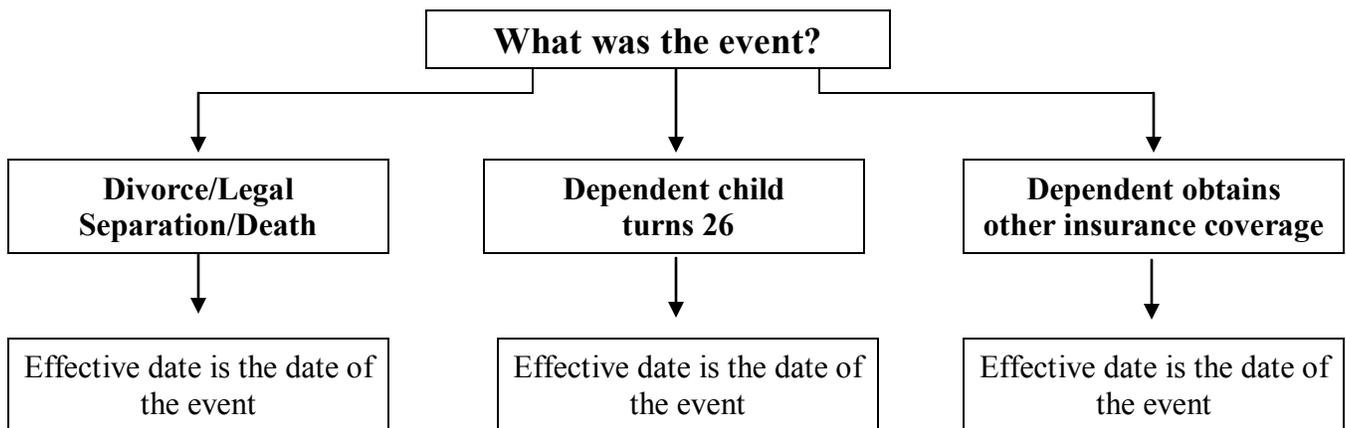
To apply for Conversion or Portability, you must apply within 31 days of the termination of your Life Insurance or within 15 days of the date you receive the COBRA notification. For questions or to apply, call The Hartford at 1.877.320.0484.



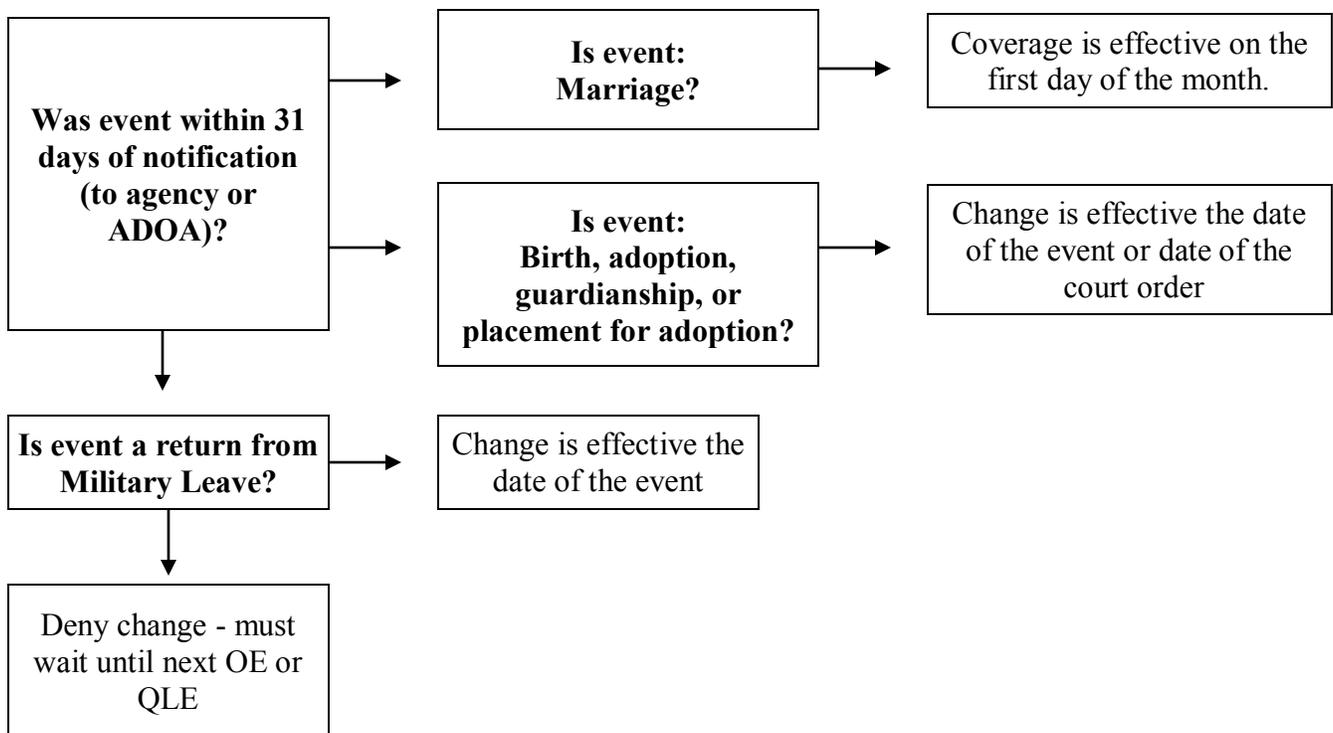
CHANGING YOUR BENEFITS FLOW CHART

The flow chart below will help you determine the effective dates for benefit changes resulting from qualifying life events.

LOSING YOUR BENEFITS



ADDING YOUR BENEFITS





SUMMARY OF MONTHLY INSURANCE PREMIUMS

Monthly Medical Premiums (Without Medicare)

		Premium Payment
EPO (Aetna, BCBSAZ/AmeriBen*, Cigna, UnitedHealthcare)	Retiree only	\$593
	Retiree +1	\$1,387
	Family	\$1,869
PPO (Aetna, BCBSAZ/AmeriBen*, UnitedHealthcare)	Retiree only	\$943
	Retiree +1	\$2,219
	Family	\$3,074

Monthly Medical Premiums (With Medicare)

		Premium Payment
EPO (Aetna, BCBSAZ/AmeriBen*, Cigna, UnitedHealthcare)	Retiree only	\$442
	Retiree +1 (Both Medicare)	\$878
	Retiree +1 (One Medicare)	\$1,024
	Family (Two Medicare)	\$1,166
PPO (Aetna, BCBSAZ/AmeriBen*, UnitedHealthcare)	Retiree only	\$789
	Retiree +1 (Both Medicare)	\$1,576
	Retiree +1 (One Medicare)	\$1,740
	Family (Two Medicare)	\$1,980

For the NAU Blue Cross Blue Shield plan rates visit:

<http://hr.nau.edu> and choose "Benefits, Health Insurances, Medical (General Health)."

**Blue Cross Blue Shield of Arizona network administered by AmeriBen. Blue Cross Blue Shield, an independent licensee of the Blue Cross Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. AmeriBen has assumed all liability for claims payment. No network access is available from Blue Cross Blue Shield Plans outside of Arizona. See page 29.*



SUMMARY OF MONTHLY INSURANCE PREMIUMS Continued

Monthly Dental Premiums

		Premium Payment
Total Dental Administrators Prepaid	Retiree only	\$8.99
	Retiree +adult	\$17.98
	Retiree +child	\$17.51
	Retiree +family	\$26.97
Delta Dental PPO plus Premier	Retiree only	\$35.94
	Retiree +adult	\$75.63
	Retiree +child	\$60.48
	Retiree +family	\$118.26

Monthly Vision Premiums

		Premium Payment
Insured plan (Avesis)	Retiree only	\$4.83
	Retiree +1	\$13.52
	Family	\$16.86
Discount card (Avesis)	Retiree	\$0.00



UNDERSTANDING YOUR INSURANCE COST

Calculating your monthly costs, premium benefit, and pension check can be simple. Each retiree's circumstances are different, but understanding how all the pieces work together will make it an easy process. First, premium benefit for the basic program varies depending on your years of service with the State of Arizona, the retirement system you are enrolled in, and the insurance plan in which you enroll. Second, ADOA, ASRS, and PSPRS offer retiree health insurance plans. Premiums differ depending on the plan option selected and whether you are enrolled in single or family coverage.

The worksheet below will help you determine the amount of insurance premiums that will be deducted from your monthly pension. In the event your pension does not cover the net premium, you will be identified as a direct pay member and will be required to pay ADOA or the insurance vendors.

NET MONTHLY HEALTH INSURANCE COST WORKSHEET			
Your monthly medical plan premium from page 10		<input type="text"/>	A
	+		
Your monthly dental plan premium from page 11		<input type="text"/>	B
Total Premium (A plus B)		<input type="text"/>	C
Your Basic Premium Benefit Subsidy (See chart on page 14)	-	<input type="text"/>	D
Your Net Premium (C minus D)	=	<input type="text"/>	E



UNDERSTANDING YOUR INSURANCE COST Continued

What You Should Know About Premium Payments

You are responsible to pay all premiums. Failure to keep your premiums current will result in cancellation of your insurance coverage. If the sum of your premium benefit subsidy and pension is greater than or equal to the total monthly premium, you will be considered a non-direct pay member. Non-direct pay members do not receive a bill.

- If you are an LTD member or Surviving Spouse not receiving a pension from a recognized state retirement plan, you are a direct pay member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form.
- If your monthly pension has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a direct pay member. The ADOA Human Resources Division, Benefit Services will mail a bill to you. It will be your responsibility to pay any outstanding premiums to ADOA Human Resources Division, Benefit Services. If you do not receive a bill by the twenty-fifth day of the month, you must contact ADOA Human Resources Division, Benefit Services.

- Should the retirement system begin deducting your premium from your pension and you have also received a bill as a direct pay member, please contact ADOA Human Resources Division, Benefit Services. Please see the section entitled, "Information for Direct Pay Members."

New Retirees/LTD Members

- Depending on when the Retirement System receives your benefit elections, you may owe one or more months of health and/or dental premiums. After enrolling, check your pension deductions. If, by your second pension, the deduction has not occurred or the deduction is incorrect, immediately contact ADOA Human Resources Division, Benefit Services at 602.542.5008.

Information for Direct Pay Members

If you are or become a direct pay member, you will receive a billing notice regarding future premium payments. If you do not receive a billing notice within 60 days, please call ADOA Human Resources Division, Benefit Services at 602.542.5008.

Vision Premium Payments

If you elect vision coverage, you will be billed directly from Avesis. Vision premiums are NOT deducted from any pension checks. Avesis will bill you directly.



UNDERSTANDING YOUR INSURANCE COST Continued

Calculating Your Premium Benefit Subsidy

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide payment toward insurance premiums for eligible members and dependents who elect health coverage through ADOA Human Resources Division, Benefit Services. The chart below reflects the maximum monthly premium benefit available for eligible members and their qualified dependents.

No basic premium benefit is provided to Retirees in the University Optional Retirement Plan or to PSPRS or CORP members who are LTD members.

Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled. To determine your basic premium benefit, you need to know:

- Your years of credited service in your retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).
- Your coverage type (i.e., single or family coverage).
- Medicare eligibility.

Basic Premium Benefit Amounts

Years of Service	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0–5.9	\$75.00	\$130.00	\$50.00	\$85.00	\$107.50	\$107.50
6.0–6.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
7.0–7.9	\$105.00	\$182.00	\$70.00	\$119.00	\$150.50	\$150.50
8.0–8.9	\$120.00	\$208.00	\$80.00	\$136.00	\$172.00	\$172.00
9.0–9.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
10.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0–5.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
6.0–6.9	\$112.50	\$195.00	\$75.00	\$127.50	\$161.25	\$161.25
7.0–7.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
8.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Corrections Officer Retirement Plan (CORP) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Public Safety Personnel Retirement System (PSPRS)						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00



UNDERSTANDING YOUR INSURANCE COST Continued

Your Direct Deposit Summary

Pension payments are issued by ASRS or PSPRS. Before either of the retirement systems generates your pension, they apply your premium subsidy (refer to the worksheet on page 12). Once the premium subsidy is added into your pension, the retirement system pays for your dental premium first. ASRS or PSPRS will apply remaining money to pay for your medical premium.

- If your pension is large enough to cover the cost of both your dental and medical premiums, you will receive any remaining money.
- If your pension is not enough to pay for the full cost of your dental and medical premiums you will become a direct pay member.

Please refer to the “Payments” column of the pension Direct Deposit Summary.

An example of an ASRS Direct Deposit Summary is shown. Please note, under the Payment Sources column, the inclusion of additional monies reflected in the premium benefit (HI PREM BENEFIT). This amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or

dental premiums you pay.

Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (HLTH INS PREM). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.

IMPORTANT NOTICE


Arizona State Retirement System
 P.O. Box 33910
 Phoenix, AZ 85067-3910

RETAIN FOR YOUR RECORDS THIS IS NOT A CHECK

 Contact Us:
 (602) 240-2000 (within metro Phoenix)
 (520) 239-3100 (within metro Tucson)
 (800) 621-3779 (toll free outside metro Phoenix and Tucson)
 www.azasrs.gov

JOHN Q PUBLIC
 1234 E FIRST ST
 MESA AZ 85205-6601

ACCOUNT ID ASR-PMM
 PLAN NAME ASRS ANNUITY - PLAN MEMBER
 CRP16 AQ001 MNT

DIRECT DEPOSIT SUMMARY					
PAYMENT DATE	SOCIAL SECURITY NUMBER		NET PAYMENT		
OCTOBER 01, 2010	000-00-0000		2,259.76		
PAYMENT DETAIL					
PAYMENT SOURCES	CURRENT	YEAR-TO-DATE	DEDUCTIONS	CURRENT	YEAR-TO-DATE
ANNUITY	2,078.42	20,784.20	FEDERAL TAX	606.00	6,050.00
PBI/EPBI	921.12	9,211.20	STTAX-AZ	153.00	1,498.00
NONTAX EXCLU	113.83	1,138.30	HLTH INS PREM	194.61	1,946.10
HI PREM BENEFIT	100.00	1,000.00			
GROSS PAYMENT	3,213.37	32,133.70	TOTAL DEDUCTIONS	953.61	9,494.10

HI PREM BENEFIT: Premium Benefit provided to you which is applied to the cost of the monthly health insurance premium for your medical and dental plan coverage.

HLTH INS PREM: Total Health Insurance Premium for the medical and dental plans in which you are enrolled before **HI PREM BENEFIT** is applied.

YOUR PAYMENT HAS BEEN ELECTRONICALLY TRANSMITTED:

Deposit Account 00000000000000000000 Bank TR# 00000000000000000000 09
 WH ELECTIONS: FED CALCULATED - S/0+250.00 STATE FLAT PERCENTAGE - 5%

NON - NEGOTIABLE



MEDICARE PART A & B

To help you calculate, use the three step worksheet on page 12. If you feel your pension is not accurate, you must notify your Retirement System (ASRS or PSPRS) as soon as possible. If your enrollment is not processed until after the third of the month, it is possible the correct premiums will not be deducted from your pension until the month following the effective date of your enrollment or change.

Eligibility

Medicare is health insurance available to people who are:

- Age 65 or over.
- Under age 65 with disabilities (receiving LTD from a State-sponsored LTD plan or SSI).
- Diagnosed with End-Stage Renal Disease.

Medicare eligibility is determined by the Social Security Administration. Many people automatically receive Part A and Part B. If you receive benefits from Social Security, you will receive Part A and Part B starting the first day of the month you turn 65. If you are under the age of 65 and disabled, you automatically receive Parts A and B after you receive disability benefits from Social Security. You should receive your Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability.

Eligibility Notification

If you become eligible to receive Medicare due to a disability, receive your Medicare Card prior to your 65th birthday, or there is a change in your Medicare status, you must contact ADOA Human Resources Division, Benefit Services with this information.

When you receive your new Medicare card, you must provide a copy of it to Human Resources Division, Benefit Services. Medicare does not communicate directly with ADOA.

Parts of Medicare

The different parts of Medicare help you cover specific health services. Medicare has the following parts:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home healthcare

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventive services to help maintain your health (See Chart on page 18)

Medicare Part C (Medicare Advantage Plans)

- A health coverage choice run by private companies approved by Medicare
- Includes Part A, Part B, and usually other coverage including prescription drugs

Standard Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

If you enroll in either Medicare Part C or Part D plan, you will not be eligible for Benefit Options Medical Coverage. (Example: if you enroll in the Humana Part D Plan, you are not eligible to Enroll with any of the ADOA Medical Plans.)



MEDICARE PART A & B Continued

Medicare Payments

- You will not typically have a monthly premium for Part A if you or your spouse paid Medicare taxes while working.
- You must pay the standard Medicare Part B premium.

Benefit Options does not pay for Medicare Part B claims. If you decline or disenroll from Medicare Part B, you will be financially responsible for ALL Part B claims.

Medicare and ADOA

If you have Medicare A & B during open enrollment, you may elect either the EPO or PPO plan offered at the “with Medicare” premium.

Medicare Primary

If you are retired and receiving a pension from a recognized State-sponsored Retirement Plan, OR you are receiving LTD benefits from a State-sponsored disability plan (Sedgwick, The Standard, Cigna, or The Hartford):

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare A and B will only pay 80% of covered charges once you have met your deductible. Doctors often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan the remaining portion less copays (20%) will be covered since Benefit Options becomes the secondary payor. Benefit Options will pay up to the total allowable amount less copays

as determined by the Plan.

Copays

A copay is a portion paid by the member to share in the cost of medical services, supplies and prescriptions. Cost sharing helps Benefit Options with healthcare costs. Medicare also applies cost sharing. For covered services, the Benefit Options plans absorb the Medicare deductible you would otherwise pay for hospital and medical services. The Benefit Options program will pay up to the total allowable amount as determined by the Plan. Most physicians charge 20% above the amount covered by Medicare. Copays are required for all plan members regardless of Medicare eligibility or disability. Your medical provider understands medical payments will be reduced by the copay. Therefore, the copay must be made at the time the services are rendered.

Medicare Crossover Program

Medicare Crossover is a process by which Medicare automatically forwards medical claims to your health plan after they have paid as the primary payor. All vendors have a Medicare Crossover program. Please call the number on the back of your card and let them know you would like to enroll in the Medicare Crossover program.



MEDICARE PART A & B

Continued

Preventive Services Checklist

Use this checklist to consult with your doctor or other healthcare provider, and ask which preventive services are right for you. Visit mymedicare.gov to find more details about the costs, how often, and whether you meet the conditions to get these services. Write down any notes and the date you receive the services to keep track of your preventive care.

Preventive Services Checklist		
Medicare-covered Preventive Services	Date of Service	Notes
Abdominal Aortic Aneurysm Screening		
Bone Mass Measurement		
Cardiovascular Screenings		
Colorectal Cancer Screenings		
Fecal Occult Blood Test		
Flexible Sigmoidoscopy		
Colonoscopy		
Barium Enema		
Diabetes Screenings		
Diabetes Self-Management Training		
Flu Vaccines		
Glaucoma Tests		
Hepatitis B Vaccines		
Mammogram (screening)		
Medical Nutritional Therapy Services		
Pap Test and Pelvic Exam (includes breast exam)		
Physical Exam (one-time “Welcome to Medicare” physical exam)		
Pneumococcal Shot		
Prostate Cancer Screenings		
Smoking Cessation (counseling to stop smoking)		



MEDICARE PART D

The Medicare Modernization Act (MMA) established a voluntary prescription drug benefit known as Medicare Part D. This benefit is offered to all Medicare eligible Retirees or LTD members enrolled in Medicare Parts A and B.

All Medicare eligible participants covered under the State of Arizona Benefit Options Program will be enrolled in a Medicare Prescription Drug Plan (PDP), a prescription drug plan that combines a standard Medicare Part D plan with additional prescription drug coverage provided by Benefit Options. The plan name is Medicare GenerationRx (Employer PDP). We refer to this program as Medicare GenerationRx for Benefit Options.

Low Income Subsidy (LIS)

Medicare eligible retirees and their Medicare eligible dependents with limited income may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare may pay for up to 100% of drug costs, and coinsurance/copayments.

Eligible members are identified during the enrollment process. Plan participants that are eligible will receive a Low Income Subsidy (LIS) Rider with their Explanation of Coverage explaining their benefit.

For more information about this, members may contact their local Social Security office or call 1.800.MEDICARE (1.800.633.4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1.877.486.2048, or visit *medicare.gov*.

Part D Income Related Adjustment Amount (IRMAA)

If your income is over \$85,000 for an individual or \$170,000 for married filing jointly, Medicare requires that you pay an additional premium based on your income. You will be notified by Social Security if this affects you.

For more information about Part D premiums based on income, visit www.medicare.gov on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Members may also call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

The Medicare GenerationRx for Benefit Options plan provides equal to or better coverage than what is offered through Medicare Part D: Learn more about Medicare GenerationRx for Benefit Options on page 36.



MEDICAL PLAN INFORMATION

Understanding Your Options

For the plan year beginning January 1, 2014 retirees have the option of two plans and four networks. The word “network” describes the company contracted with the State to provide access to a group of providers (e.g., doctors, hospitals). Certain providers may belong to one network but not another. Plans are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-network coverage associated with your medical benefit.

	EPO	PPO
Aetna	X	X
BCBSAZ/AmeriBen*	X	X
Cigna	X	
UnitedHealthcare	X	X

*Blue Cross Blue Shield of Arizona network administered by AmeriBen.

How the Plans Work

As noted below there are two medical plans offered to retirees under Benefit Options. They are the Exclusive Provider Organization (EPO) and the Preferred Provider Organization (PPO).

The EPO Plan

If you choose the EPO plan under Benefit Options you must obtain services from a network provider. Out-of-network services are only covered in emergency situations.

Under the EPO plan, you will pay the monthly premium and any required copay at the time of service. The EPO plan is available with all four networks: Aetna,

BlueCross Blue Shield of Arizona network administered by AmeriBen, Cigna and UnitedHealthcare.

The PPO Plan

If you choose the PPO plan under Benefit Options you can see providers in-network or out-of-network, but will have higher costs for in-network and out-of-network services. Additionally, there is an in-network and out-of-network deductible that must be met. Under the PPO plan, you will pay the monthly premium and any required copay or coinsurance (percent of the cost) at the time of service. The PPO plan is available with Aetna, Blue Cross Blue Shield of Arizona network administered by AmeriBen, and UnitedHealthcare.

Choosing the Best Plan for You and Your Family

The first thing to know when making your medical benefit elections with Benefit Options is that the coverage is the same for all choices. This means that the same services are covered under the EPO and PPO, but the network of providers is different. To choose the right plan:

1. Assess the costs you expect in the coming year including: monthly premiums, copays, and out-of-pocket. Refer to pages 10-11 for monthly premiums and page 26 for the plan comparisons to help determine cost.
2. Determine if your doctors and specialists are contracted with the network you are considering. Each medical network has a



MEDICAL PLAN INFORMATION Continued

website or phone number (under Contacts) for you to determine if your doctor is contracted.

3. Once you have selected which plan best suits your needs and your budget, make any changes to your benefit by completing the 2014 Enrollment Form.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a provider who is not contracted with one of the new networks, you can apply for transition of care. If you are approved, you will receive in-network benefits for your current provider during a transitional period after January 1, 2014. Transition of care is typically approved if one of the following applies:

1. You have a life threatening disease or condition;
2. You have been receiving care and a continued course of treatment is medically necessary;
3. You are in the third trimester of pregnancy; or
4. You are in the second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies, procedures, and quality assurance requirements.

TOC forms are available on the Benefit Options website benefitoptions.az.gov.

Effective Dates and ID Cards

Your personal insurance cards typically arrive 7-14 business days after your benefits first become effective.

If you do not make changes to your current benefits, you can continue to use your current ID card, a new card will not be sent.

Contacts

Aetna: 1.866.217.1953
aetnastateaz.com

Blue Cross Blue Shield of Arizona Network administered by AmeriBen: 1.866.955.1551
MyAmeriBen.com/arizona2.htm

Cigna: 1.800.968.7366
Cigna.com/stateofaz

UnitedHealthcare: 1.800.896.1067
welcometouhc.com/stateofaz



MEDICAL ONLINE FEATURES

You can review your personal profiles, view the status of medical claims, obtain general medical information, and learn how to manage your own healthcare through the available health plan websites.

Aetna

Non-member: aetnastateaz.com

Existing member: aetna.com

DocFind

You can find out if your physician or hospital is contracted with Aetna.

Aetna members can create a user name and password and have access to:

Aetna Navigator—Review Your Plan and Benefits Information

Verify your benefits and eligibility. You will also have access to a detailed claims status and claim Explanation of Benefits (EOB) statements.

ID Card

Print a temporary or order a replacement ID card.

Contact and E-mail

Access contact information for Aetna Member Services as well as Aetna's 24/7/365 NurseLine. Chat live with member service representatives by using Live Help feature .

Estimate the Cost of Care

You can estimate the average cost of healthcare services in your area including medical procedures and medical tests.

Health Information—Simple Steps to Healthier Life

This website will give access to wellness information.

Smart Source

Access information and resources on a variety of health and wellness topics and learn more about programs and services.

Personal Health Record

Access and print historical claims information.

Aetna Mobile

Type aetna.com in your smart phone to access doctors, Aetna Navigator, and much more. There is an I-Phone application available for downloading.





MEDICAL ONLINE FEATURES Continued

Blue Cross Blue Shield of Arizona Network Administered by AmeriBen

Non-member: [www.myameriben.com/
arizona2.htm](http://www.myameriben.com/arizona2.htm)

Existing member: MyAmeriBen.com

Blue Cross® Blue Shield® of Arizona (an independent licensee of the Blue Cross and Blue Shield Association) provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

Lookup Provider

To find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona Network administered by AmeriBen use this tool.

Blue Cross Blue Shield of Arizona Network administered by AmeriBen members can create a user ID and password to have access to:

HealthGrades

Perform research on over 5,000 hospitals nation-wide. Access easy to understand ratings for recoveries, complications, and survival rates.

Hospital Compare

In this tool you will find information on how well hospitals care for patients with certain medical conditions or surgical procedures,

and results from a survey of patients about the quality of care they received during a recent hospital stay.

Claims Inquiry

View and read the detailed status of all medical claims submitted for payment. You can also obtain your Explanation of Benefits (EOB).

Optional Electronic Paperless EOB

Reduce mail, eliminate filing and help the planet by going green.

Coverage Inquiry

Verify eligibility for you and your dependents.

Wellness Tools

You can have access to wellness information.

Online Forms

You can submit and complete important health forms online, including filing an appeal.

Help

You can instant message AmeriBen with questions about your benefits, claims or general information about your health plan.





MEDICAL ONLINE FEATURES

Continued

Cigna

Non-member: cigna.com/stateofaz

Existing member: mycigna.com

For retirees not enrolled on the Cigna plan, visit cigna.com/stateofaz for a provider listing, program and resource information.



For retirees already enrolled on the Cigna plan, please visit mycigna.com, and have access to:

Personal Profile

You can verify your coverage, copays, deductibles, and view the status of claims.

ID Card

Order a new ID card or print a temporary one.

Evaluate Costs

You can find estimated costs for common medical conditions and services.

Rank Hospitals

Learn how hospitals rank by cost, number of procedures performed, average length of stay, and more.

Assess Treatments

You can get facts to make informed decisions

about condition-specific procedures and treatments.

Conduct Research

With an interactive library, you can gather information on health conditions, first aid, medical exams, wellness, and more.

Health Coaching

Take a quick health assessment, get personalized recommendations and connect to immediate online coaching resources.

Monitor Health Records

Keep track of medical conditions, allergies, surgeries, immunizations, and emergency contacts.



You can download a free, personalized smartphone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating doctors and hospitals, and so much more. Get the myCigna Mobile app today!

Note: All Mayo Clinic Primary Care Physicians (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the \$30 specialist copayment.



MEDICAL ONLINE FEATURES

Continued

UnitedHealthcare

Non-member: welcometouhc.com/stateofaz

Existing member: myuhc.com[®]

Visit your support site: welcometouhc.com/stateofaz

From this site you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more.

- View and compare benefit plan options
- Learn more about wellness programs, specialized benefits and online tools
- Search for physicians and facilities
- And, access our site for members, myuhc.com

Your health, your questions, your myuhc.com

Once you become a member, your first stop is your member website, myuhc.com. It's loaded with details on your benefit plan and much more.



Need a new doctor or a specialist?

Click “*Find a doctor*” to search for doctors near you. You can even see which physicians have been recognized by the UnitedHealth Premium program[®] for having met national quality standards and local benchmarks for cost-efficiency.

Want to get rid of that nagging pain, but worried about the cost?

The health care cost estimator tool may help you get the best care for the best cost. Click on “*Estimate Health Care Costs*” to get started. It will guide you through the steps to get your estimate and provide you information about the procedure, risks, and benefits along the way.

Looking for an easier way to manage claims?

Click on “*Manage My Claims*” to easily search for claims, track claims you need to watch, mark claims you’ve already paid, and use easy-to-read graphs to better understand your bills and what you owe.

Want a place to keep your personal health information?

The “*Health & Wellness*” tab is your own personal website that is designed to:

- Inspire healthy action with a step-by-step program
- Encourage you to remain motivated through online health programs, and innovative tools and calculators that track your progress
- Reinforce your commitment by acknowledging your accomplishments

Always on the go? We can help you there too.

Whether you need to find urgent care, you forget your health plan ID card, or need to call customer service, the UnitedHealthcare Health4Me™ mobile app helps put your insurance information in the palm of your hand.



MEDICAL PLANS COMPARISON CHART

		EPO	PPO	PPO
Available Plans		<input checked="" type="checkbox"/> Aetna	<input checked="" type="checkbox"/> Aetna	<input checked="" type="checkbox"/> Aetna
		<input checked="" type="checkbox"/> BCBSAZ/AmeriBen*	<input checked="" type="checkbox"/> BCBSAZ/AmeriBen*	<input checked="" type="checkbox"/> BCBSAZ/AmeriBen*
		<input checked="" type="checkbox"/> Cigna	<input checked="" type="checkbox"/> UnitedHealthcare	<input checked="" type="checkbox"/> UnitedHealthcare
		<input checked="" type="checkbox"/> UnitedHealthcare		
		IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Plan year deductible	Single retiree	none	\$500**	\$1,000**
	Retiree+adult, retiree+child, family	none	\$1,000** +	\$2,000**
Out-of-pocket max	Single retiree	none	\$1,000** +	\$4,000**
	Retiree+adult, retiree+child, family	none	\$2,000**	\$8,000**
Lifetime max		none	none	none
RETIREE COST FOR CARE				
Behavioral health	Inpatient	\$150	\$150	50% after deductible
	Outpatient	\$15	\$15	50% after deductible
Chiropractic		\$15	\$15	50% after deductible
Durable medical equipment		\$0	\$0	50% after deductible
Emergency ER copay waived if admitted	Ambulance	\$0	\$0	Amount above in-network rate
	ER	\$125	\$125	\$125
	Urgent care	\$40	\$40	50% after deductible
Home health services				
Maximum visits per year		42	42	
Hospital admission (Room and Board)		\$150	\$150	50% after deductible
Mammography		\$0	\$0	50% after deductible
Office visits Max of 1 copay/day/provider	PCP	\$15	\$15	50% after deductible
	Specialist	\$30	\$30	50% after deductible
	Preventive	\$15	\$15	50% after deductible
	OB/GYN	\$10	\$10	50% after deductible
Outpatient services				
Freestanding ambulatory facility or hospital outpatient surgical center		\$50	\$50	50% after deductible
Radiology		\$0	\$0	50% after deductible

*Blue Cross Blue Shield of Arizona network administered by AmeriBen.

**Copays apply to out-of-pocket maximum after deductible is met for PPO plans. The plan pays 100% after out-of-pocket maximum is met.

+ PPO in-network deductible must be met before copay applies.

For the NAU only BCBS PPO plan details, go to <http://hr.nau.edu/m> and choose Benefits, Health Insurances, Medical (General Health), BCBS Plan Book.



MEDICAL MANAGEMENT

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. **You get personalized medical management programs at no additional cost.** Under the Benefit Options health plan, there are four medical management vendors: American Health Holding (AHH), Aetna, Cigna, and UnitedHealthcare. Each vendor serves their specific members based on which medical network you select during enrollment.

The four vendors provide medical management services as follows:

- American Health Holding (AHH) serves Blue Cross Blue Shield of Arizona administered by AmeriBen members only
- Aetna serves only Aetna members
- Cigna serves only members enrolled with the Cigna network
- UnitedHealthcare serves only UnitedHealthcare members

Professional, experienced staff work on your behalf to make sure you are getting the best care possible and that you are properly educated on all aspects of your treatment.

Utilization Management

AHH, Aetna, Cigna, and UnitedHealthcare provide prior authorization and utilization review for the Benefit Options plan when members require non-primary care services. Prior to any elective hospitalization and/or certain outpatient procedures, you or your doctor must contact your designated medical management vendor for Authorization. Please refer to your Plan

Document posted at benefitoptions.az.gov for the specific list of services that require prior authorization. Each vendor has a dedicated line to accept calls and inquiries:

American Health Holding 1.866.244.8977

Aetna 1.800.333.4432

Cigna 1.800.968.7366

UnitedHealthcare 1.800.896.1067

Case Management

Case management is a collaborative process whereby a case manager from your designated medical management vendor works with you to assess, plan, implement, coordinate, monitor, and evaluate the services you may need. Often case management is used with complex treatments for severe health conditions. The case worker uses available resources to achieve cost effective health outcomes for both the member and the Benefit Options plan.

Disease Management

The purpose of disease management programs is to educate you and/or your dependents about complex or chronic health conditions. The programs are typically designed to improve self-management skills and help make lifestyle changes that promote healthy living.

The following disease management programs are available to all Benefit Options members regardless of their selected networks:

- Asthma
- Diabetes



MEDICAL MANAGEMENT

Continued

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Pregnancy/Maternity
- Coronary Artery Disease

If you are eligible or become eligible for one of the programs listed, a disease manager from your designated medical management vendor will assess your needs and work with your physicians to develop a personalized plan. Your personalized plan will establish goals and steps to help you to positively change your specific lifestyle habits and improve your health.

Your assigned disease manager may also:

- Provide tips on how to keep your diet and exercise program on track
- Help you to maintain your necessary medical tests and annual exams
- Offer tips on how to manage stress and help control the symptoms of stress
- Assist with understanding your doctor's treatment plan
- Review and discuss medications, how they work and how to use them.

Generally a disease manager will work with you as quickly or as slowly as you like, allowing you to complete the program at your own pace. Over the course of the program participants learn to incorporate healthy habits and improve their overall health.

Getting Involved

The Benefit Options disease management programs offered through American Health Holding, Aetna, Cigna, and UnitedHealthcare identify and reach out through phone calls and/or mail to members who may need help managing their health conditions. The disease management companies work with the Benefit Options plan to provide this additional service.

Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective disease management vendors directly to self enroll. Please refer to the your medical management vendor's phone number on page 27 if you or your dependent is interested.

NurseLine

A dedicated team of nurses, physicians and/or dietitians are available 24/7 for member consultations. Members needing medical advice or who have treatment questions can call the toll-free nurseline:

American Health Holding
1.866.244.8977

Cigna 1.800.968.7366

Aetna 1.800.556.1555

UnitedHealthcare 1.800.401.7396



NETWORK OPTIONS OUTSIDE OF ARIZONA

The charts below indicate the coverage options and networks for members who live out-of-state. All four medical networks offer statewide and nationwide coverage and are not restricted to regional areas. All plans are available in all domestic locations. However, not all plans have equal provider availability, so it is important to check with your current provider to determine if he/she is contracted with your selected health plan network.

EPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Select Open Access
BCBSAZ/ AmeriBen* +	BCBS of Arizona network for In-State Services	PHCS / MultiPlan for Nationwide Services
Cigna	Nationwide	Cigna Open Access Plus
UHC	Nationwide	UHC Choice

PPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Choice POS II Open Access
BCBSAZ/ AmeriBen* +	BCBS of Arizona network for In-State Services	PHCS / MultiPlan for Nationwide Services
UHC	Nationwide	UHC Options PPO

**Blue Cross Blue Shield of Arizona network administered by AmeriBen.*

+ The Blue Cross Blue Shield of Arizona network administered by AmeriBen is only available in Arizona. AmeriBen has made the PHCS / MultiPlan network available to those members living out of state.



PRE-MEDICARE PHARMACY PLAN INFORMATION

MedImpact

If you elect any Benefit Options medical plan, MedImpact will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan and there is no separate cost.

MedImpact currently services 35 million members nationwide, providing leading prescription drug clinical services, benefit design, and claims processing since 1989 through a comprehensive network of pharmacies.

How it works

All prescriptions must be filled at a network pharmacy by presenting your medical card. You can also fill your prescription through the mail order service. **The cost of prescriptions filled out-of-network will not be reimbursed.**

No international pharmacy services are covered. Be sure to order your prescriptions prior to your trip and take them with you.

The MedImpact plan has a three-tier formulary described in the chart on page 35. The copays listed in the chart are for a 30-day supply of medication bought at a retail pharmacy.

Generic and brand name medications

If a name brand medication is prescribed by a physician as “substitution permissible” and a generic version of the medication is available, members who elect to purchase the brand name medication will pay the copay

and the difference between the cost of the brand-name medication and the cost of the generic version.

For example: The cost of a brand name medication is \$100 and the cost of the generic version is \$30 with a \$10 copay. When prescribing the medicine, if the physician indicates that either the brand name or the generic equivalent is acceptable, then the cost for the brand name will be \$80 (\$100 brand name - \$30 generic +\$10 copay) if the member elects the brand name, or \$10 for the generic version. If the physician specifically prescribes the brand name to the member and does not allow for any substitution of a generic version, the member will have to **pay the generic copay and the difference between the cost of the brand name and the generic.**

Generic drugs help you save money without compromising quality. The United States Food and Drug Administration (FDA) require generics to be as safe and effective as their brand name counterparts. Nearly 50% of all prescriptions in the U.S. are now filled with generic medications. Your doctor may choose to prescribe a generic for you, or, if he or she recommends a brand name, you can ask if a generic is available. Pharmacists will usually substitute a generic for a brand name, unless otherwise directed by your doctor or prohibited by law. You will pay the lowest copay for generic drugs. Generic drug prices on average are 20 to 50 percent lower than their brand-name counterparts, so your choice of generics can help keep the Plan’s costs down and benefits high.



PRE-MEDICARE PHARMACY PLAN INFORMATION Continued

Formulary

A formulary is a list of medications chosen by a committee of doctors and pharmacists to help you maximize the value of your prescription benefit. These generic and brand name medications are available at a lower cost. The use of non-preferred medications will result in a higher copay. Changes to the formulary can occur during the plan year. Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled. To see what medications are on the formulary, go to benefitoptions.az.gov or contact the MedImpact Customer Care Center and ask to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the best value for the medications you need, which saves money for you and your Plan.

Finding a Pharmacy

To find a pharmacy refer to benefitoptions.az.gov. See online features for more information.

The Customer Care Center is available 24 hours a day, 7 days a week. The toll-free telephone number is 1.888.648.6769.

Medication Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription.

These prescriptions may be limited to quantity, frequency, dosage or may have age restrictions.

The authorization process may be initiated by you, your local pharmacy, or your physician by calling MedImpact at 1.888.648.6769.

For a complete list of drugs under this program please refer to the formulary at benefitoptions.az.gov.

Medications for the following conditions through the Specialty Pharmacy Program include, but are not limited to:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Step Therapy Program

Step Therapy is a program which promotes the use of safe, cost-effective and clinically appropriate medication.

This program requires that members try a generic alternative medication that is safe and equally effective before a brand name medication is covered.

For a complete list of drugs under this program, please refer to the formulary at benefitoptions.az.gov.



PRE-MEDICARE PHARMACY PLAN INFORMATION Continued

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Specialty Pharmacy Program. This program assists you with monitoring your medication needs and also provides patient education.

The Walgreens Specialty Pharmacy Program includes monitoring of specific injection drugs and other therapies requiring complex administration methods and special storage, handling, and delivery. Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or through the Walgreens Specialty Central Fill facility by calling 1.888.782.8443.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Pharmacy Program. You may also enroll directly into the program by calling 1.888.782.8443.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for retirees who require medications for on-going health conditions or who will be in an area with no participating retail pharmacies for an extended period of time.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of

medication for **two copays**.

- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at *walgreens.com* or via phone at 1.866.304.2846.

Have your insurance card ready when you call!

Choice90

With this program, retirees who require medications for an on-going health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays**. For more information contact MedImpact Customer Care Center at 1.888.648.6769.

Limited Prescription Drug Coverage

Prescription drug coverage will generally be limited to medications that do not have an equally effective over-the-counter substitute.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

Extended Vacation or Working Abroad

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify MedImpact in writing of why



PRE-MEDICARE PHARMACY PLAN INFORMATION Continued

you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone.

MedImpact will be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *providing you have the appropriate number of refills remaining.*

Order refills at least two weeks in advance of your departure. If there is a problem, such as, *not enough refills*, you will have enough time to phone your physician. If you are using Mail Order, contact MedImpact at least three weeks in advance.

Copays will be the same as you would normally pay times the number of refills you need.

If you are already out of town and need a prescription call MedImpact. Tell the representative you are out of town and need to find a participating pharmacy in the area where you are. You will need the zip code where you are visiting. In most cases you will have several choices. If your medication is lost, stolen, or damaged, replacement medication is not covered.

Contacts

	Phone
<i>MedImpact</i>	
Customer Care Center and Prior Authorization	1.888.648.6769
<i>Walgreens</i>	
Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

NAU Retiree BCBS

Member only

There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, non-preferred brand A, or non-preferred brand B copay.

The BCBSAZ Prescription Medication Guide can be used to determine your copay and this guide can be found on the BCBS website at <http://www.bcbsaz.com/Medications/Tiere-d-Copay-Plans.aspx>. Go to 4 level prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Walgreens Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copay for the 90-day supply is equivalent to one month's copay.



PRE-MEDICARE PHARMACY ONLINE FEATURES

Pre-Medicare members can view pharmacy information located at benefitoptions.az.gov. Click on the pharmacy link and go to the Retired State Employees, Pre-Medicare Pharmacy Benefits, and click on MedImpact Pharmacy Website.

Members can create a user name and password to have access to:

Benefit Highlights

View your current copay amounts and other pharmacy benefit considerations.

Formulary Lookup

Research medications to learn whether they are generic, preferred or nonpreferred drugs. This classification will determine what copay is required. You can search by drug name or general therapeutic category.

Prescription History

View your prescription history, including all of the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.

Drug Search

Research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.

Health & Wellness

Learn valuable tips and information on diseases and health conditions.

Mail Order

A link will direct you to the Walgreens website where you may register for mail

order service by downloading the registration form and following the instructions.

Locate a Nearby Pharmacy

Locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

Generic Resource Center

Learn more about generic drugs and savings opportunities.

Choice90

Learn more about the Choice90 option. With this program, you can obtain a 90-day supply of medication for a reduced copay.

NAU Retirees only Blue Cross/Blue Shield Members

Refer to more information by accessing Blue Net, BlueCross/ BlueShield of Arizona's online member website at www.bcbsaz.com. Information on the pharmacy plan and copay levels for prescriptions can be found at <http://www.bcbsaz.com/Medications/Tiered-Copay-Plans.aspx> go to 4-level prescription drug benefit.



PRE-MEDICARE PHARMACY BENEFITS SUMMARY

	ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona network administered by AmeriBen, Cigna, UnitedHealthcare)	BC/BS NAU Only www.bcbsaz.com
Pharmacy Benefits Administered By	MedImpact	Blue Cross / Blue Shield
Retail Requirements	In-Network pharmacies only: one copay per prescription	In-network only: one copay per prescription
Mail Order	Two copays for 90-day supply	One copay for 90-day supply
Choice90	Two & 1/2 copays for 90-day supply	Not Available
Generic	\$10 copay	\$10 copay
Preferred Brand*	\$20 copay	\$25 "brand"
Non-Preferred Brand*	\$40 copay	\$45 for non-preferred brand "A"
		\$85 for non-preferred brand "B"
Annual Maximum	None	None

**Member may have to pay more if a brand is chosen over a generic.*

Note: Copays for compounded medications are based on the formulary placement of the main compound ingredient.





MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION

Medicare GenerationRx (Employer PDP) for Medicare eligible retirees & Medicare eligible dependents
 Effective January 1, 2014, if you elect any Benefit Options medical plan, you will be automatically enrolled in the Benefit Options Medicare GenerationRx Employer Prescription Drug Program (PDP).

Medicare GenerationRx Employer PDP is sponsored by Stonebridge Life Insurance Company, a Medicare approved Part D sponsor. All Medicare GenerationRx communications will include the Medicare GenerationRx logo.



How it Works

Medicare eligible retirees and their Medicare eligible dependents enrolled in Medicare GenerationRx will each receive their own prescription drug ID card.

The new ID card will be issued by Medicare GenerationRx, and will NOT replace your medical card. The new prescription drug ID card is in addition to your medical card. Show your Medicare GenerationRx card when you fill your prescription medications at the pharmacy.

Members will need to use their new Medicare GenerationRx prescription ID card if they're enrolled in Medicare GenerationRx Part D Prescription Drug Program for Benefit Options. Members will receive their new card within 10 days of their effective date.

All prescriptions must be filled at a Network pharmacy by presenting your Medicare GenerationRx prescription ID card. You can also fill your prescription through the Walgreens mail order service.

The Medicare GenerationRx for Benefit Options plan has a four-tier formulary.

The Plan provides you full coverage so there is no Coverage Gap, or "Donut Hole." This allows your cost sharing to remain consistent. You pay the same copays throughout the year during all the Medicare Part D stages.

If you reach the catastrophic coverage stage (\$4,550 in total out-of-pocket costs for 2014), your Benefit Options copayment will be the maximum amount charged.

Benefits, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

The benefit information provided is a brief summary, not a complete description of benefits.

Additional limitations, copayments, and restrictions may apply. For more information contact Medicare GenerationRx.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help maximize the value of your prescription benefit.



MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

Tier Number / Name	Retail (up to 31-day supply)	Mail Order (up to 90-day supply)	Choice90Rx – extended supply at retail (up to 90-day supply)
Tier 1: Generic	\$10	\$20	\$25
Tier 2: Preferred Brand	\$20	\$40	\$50
Tier 3: Non-Preferred Brand	\$40	\$80	\$100
Tier 4: Specialty - Over \$600*	\$40	Not available	Not available

* Total medication cost.

Members will use Medicare GenerationRx’s 4 tier formulary. Generic and brand name medications are available at a lower cost.

The use of non-preferred medications will result in a higher copay. Changes to the formulary can occur during the plan year. Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled.

Some drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. You or your physician will need to obtain approval from Medicare GenerationRx before you fill your prescriptions.

- **Step Therapy Program:** The program promotes the use of safe, cost-effective and clinically appropriate medications. This program requires that members try a generic alternative medication that is safe and equally effective before a brand name medication is covered.
- **Quantity Limits:** For certain drugs, Medicare GenerationRx limits the amount of the drug that Medicare GenerationRx will cover.

To see what medications are on the formulary and get additional information about drug restrictions, go to medicaregenerationrx.com/stateofaz or call Medicare GenerationRx’s Member Services at 1.877.633.7943. TTY users should call 711. Member Services is open 24 hours a day, 365 days a year. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.



MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

Finding a Pharmacy

Medicare GenerationRx has over 65,000 pharmacies in its network. Members may continue to fill their prescriptions at their current pharmacy as long as it is a MedicareGenerationRx for Benefit Options network pharmacy. Members will receive a pharmacy directory based on their permanent address as part of the Welcome Kit. Members may request additional directories from Member Services or use the online Pharmacy Locator at medicaregenerationrx.com/stateofaz.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for members who need medications for ongoing health conditions or who will be in an area with no participating retail pharmacies for an extended period of time.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician, but verification is required every 30 days.
- Auto refill is not available.
- Request up to a 90-day supply of medication for **two copays**.
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at Walgreens.com or via phone at 1.866.304.2846. Have your prescription card ready when you call!

Choice90Rx

With this program, members who require medications for an ongoing health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays**.

For more information or to find a participating Choice90Rx pharmacy, please visit our web site at medicaregenerationrx.com/stateofaz, refer to your Pharmacy Directory or call Medicare GenerationRx Member Services at 1.877.633.7943, 24 hours a day/365 days a year. TTY/TDD users should call 711.

Specialty Pharmacy Program

If you are taking a medication that is on the Specialty tier of your prescription benefit, you may use Walgreens Specialty pharmacy, or any specialty pharmacy in the Medicare GenerationRx specialty pharmacy network.*

To enroll in Walgreens Specialty Pharmacy's Patient Care Programs, please call 1.888.782.8443 to speak with a Patient Care Coordinator. Walgreens Specialty Pharmacy will reach out to your health care provider to get a new prescription for you or have your specialty prescriptions transferred from your current pharmacy. For more information on Walgreens Specialty Pharmacy, visit walgreens.com/specialty.

Specialty medications are limited to a 31-day supply.

*Other pharmacies are available in our network.



MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

New Under Medicare Part D

Extra Help (Low Income Subsidy)

An added benefit of switching to the plan is that Medicare eligible retirees and their dependents with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to 100% of drug costs including annual deductibles (if applicable), and coinsurance/copayments.

Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many Medicare eligible retirees and their dependents are eligible for these savings and don't even know it.

Members eligible for “Extra Help” are identified during the enrollment process. Plan participants that are eligible will receive a Low Income Subsidy (LIS) Rider with their Explanation of Coverage explaining what their benefit will be.

For more information about Extra Help, members may contact their local Social Security office or call **1.800.MEDICARE** (1.800.633.4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1.877.486.2048, or visit *medicare.gov*.

Part D Income Related Adjustment Amount (IRMAA) OR “Extra Amount”

Some Medicare eligible members and their dependents pay an extra amount for Part D because of their yearly income. If a member's income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, they must pay an extra amount directly to the government (not the Medicare plan) for Medicare Part D coverage.

- If a member is required to pay the extra amount and does not pay it, they will be disenrolled from the plan and lose prescription drug coverage.
- If the member needs to pay an extra amount, Social Security, not the Medicare plan, will send the member a letter telling them what that extra amount will be.
- For more information about Part D premiums based on income, visit *medicare.gov* on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Members may also call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

The booklet *Medicare & You 2014* gives information about the Medicare premiums in the section called “2014 Medicare Costs.” This explains how the Medicare Part B and Part D premiums differ for Medicare eligible members and their dependents with different incomes.



MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2014* from the Medicare website (*medicare.gov*). Or, you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members also pay a premium for Medicare Part B.

Members who owe the income-related adjustment amount (IRMAA or "extra amount") will receive a letter directly from the Social Security Administration (SSA). Medicare GenerationRx is not aware whether the member qualifies for this additional premium or not as it is managed strictly through the SSA.

We are only made aware if the member is disenrolled for non-payment. See Ch. 4, Section 11 of the EOC for more information about the extra amount.

If a member feels they should not have to pay the additional premium, they should call the SSA number listed in the letter.

SSA will either make an appointment for the

member at their local SSA office or they will transfer them to the local SSA phone number for an income re-determination.

A member's income may have increased/decreased due to capital gains (e.g. sale of a home, cashing in a 401k, marriage, divorce or death).

Extended Vacation or Travel Abroad

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need.

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify Medicare GenerationRx in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone.

Medicare GenerationRx will generally be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *providing you have the appropriate number of refills remaining*.

Order refills at least two weeks in advance of your departure. If there is a problem, such as, *not enough refills*, you will have enough time to phone your physician.



MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

Copays will be the same as you would normally pay times the number of refills you need.

Medicare GenerationRx cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Contact information

Medicare GenerationRx Member Services is available to address pharmacy plan questions. Representatives are available **24 hours a day, 365 days a year** at **1.877.633.7943**. **TTY users should call 711**. Language translation services are available.

Pharmacies and providers may call the Medicare GenerationRx Pharmacy & Provider Help Desk at **1.888.678.7789**. Representatives are available **24 hours a day, 365 days a year**. **TTY users should call 711**.

To view your Medicare GenerationRx for Benefit Options plan benefits find a participating pharmacy or look up the price of your drugs, visit medicaregenerationrx.com/stateofaz.



MEDICARE ELIGIBLE PHARMACY ONLINE FEATURES

Members can view pharmacy information located at medicaregenerationrx.com/stateofaz.

Members can create a user name and password to have access to:

Benefit Highlights

View your current copay amounts and other pharmacy benefit considerations.

Formulary Lookup

Research medications to learn whether they are generic, preferred or nonpreferred drugs. This classification will determine what copay is required. You can search by drug name or general therapeutic category.

Prescription History

View your prescription history, including all of the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.

Drug Search

Research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.

Health & Wellness

Learn valuable tips and information on diseases and health conditions.

Mail Order

A link will direct you to the Walgreens website where you may register for mail order service by downloading the registration form and following the step-by-step instructions. Auto refill is not available.

Locate a Nearby Pharmacy

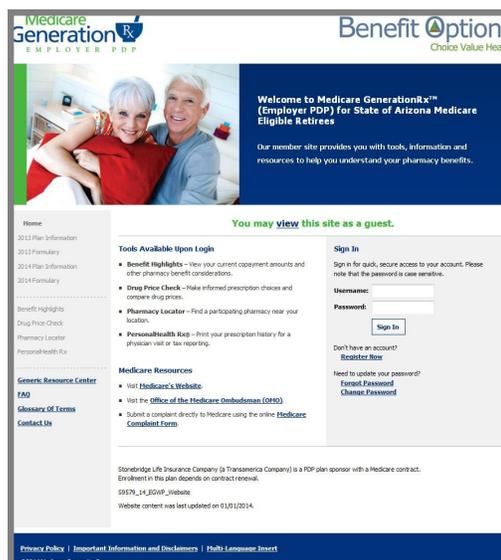
Locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

Generic Resource Center

Learn more about generic drugs and savings opportunities.

Choice90Rx

Learn more about the Choice90Rx option. With this program, you can obtain a 90-day supply of medication for a reduced copay.





DENTAL PLAN INFORMATION

Dental Plan Options

Retirees may choose between two plan types. They are the Prepaid/DHMO and the Indemnity/Preferred Provider Organization (PPO) plan. Each plan's notable features are bulleted below.

Prepaid/DHMO Plan – Total Dental Administrators Health Plan, Inc. (TDAHP)

- You MUST use a DHMO/Prepaid Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums.
- No waiting periods.
- Pre-existing conditions are covered.
- Specific copays for services.
- Specific lab fees for prosthodontic materials.

Each family member may choose a different general dentist. You can select or change your dentist by contacting TDAHP by telephone or using the "change my dentist" function on the website TDAdental.com/adao. Members may self-refer to dental specialists within the network.

Specialty care copays are listed in the plan booklet. Specialty services not listed are provided at a discounted rate. This discount includes services at a Pedodontist, Prosthodontist, and TMJ care.

Indemnity/PPO Plan – Delta Dental PPO plus Premier

- Your preventive and diagnostic services are covered at 100% and are not

- are covered at 100% and are not subtracted from your annual maximum.
- Your annual maximum benefit is \$2,000 per benefit year.
- No deductible for diagnostic and routine services.
- \$50 deductible per person and no more than \$150 per family.
- The maximum lifetime benefit for orthodontia is \$1,500.
- A third dental cleaning per benefit year is available for eligible members.
- A no missing tooth clause is included.
- You can elect to see a licensed dentist anywhere in the world.
- Delta Dental has the largest network in Arizona with 3,100+ participating dentists.
- You can maximize your benefits when you select a PPO Provider.
- Delta Dental dentists have agreed to accept a negotiated fee (after deductibles and copays are met) and can't balance bill you in excess of the allowed fee.
- Claims are filed by the dentist and they are paid directly, making it easier for you.

To find a Delta Dental dentist near you, please visit deltadentalaz.com/find.

How to Choose the Best Dental Plan for You

When choosing between a prepaid/DHMO plan and an indemnity/PPO plan, you should consider: dental history, level of dental care required, costs/budget and provider in the network. If you have a dentist, make sure he/she participates on the plan (prepaid/DHMO plan -TDAHP or indemnity/PPO - Delta Dental PPO plus Premier) you are considering.



DENTAL PLAN INFORMATION & ONLINE FEATURES Continued

For a complete listing of covered services for each plan, please refer to the plan description located on benefitoptions.az.gov.

New enrollees should receive a card within 10-14 business days after the benefits become effective.

Total Dental Administrators Health Plan (TDAHP), Inc.

If you are enrolling with TDAHP, go to TDAdental.com/adoa to access the online features described below.

Participating Providers

You can search for a specific dentist contracted under this plan (DHMO/Prepaid) by visiting TDAdental.com/adoa.

Select or Change Participating Provider

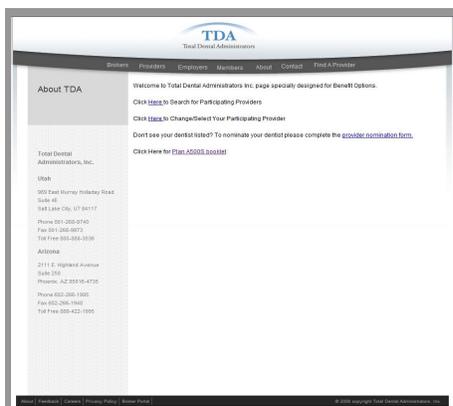
You can select or change your specific participating provider.

Nominate a Dentist

If you have a preferred dentist that is not a participating provider, you can nominate your dentist to be included in the plan.

Plan A500AZ

Learn about the plan by clicking on this option.



Delta Dental PPO plus Premier

Your Delta Dental plan comes with a range of online features designed to make using and managing your benefits easy and convenient. After the benefit year begins on January 1, please visit deltadentalaz.com to create your ID and password in the **Member Connection**, a secure online environment that gives you access to the following tools and materials:

- State of Arizona PPO plus Premier Plan information.
- View and/or print your **benefits and eligibility**.
- Sign up for **electronic Explanation of Benefits (EOBs)**.
- **24/7 claims information**
- View **instructional videos**.
- **Find a Dentist** tool allows you to search the national directory by zip code.
- **Nominate your dentist** to be a contracted dentist if they aren't.
- Assess your risk using the **Dental Disease Tool**.





DENTAL PLANS COMPARISON CHART

	TDAHP Total Dental Administrators	Delta Dental
PLAN TYPE	Prepaid/DHMO	Indemnity/PPO
DEDUCTIBLES	None	\$50/\$150
PREVENTIVE CARE CLASS I		
Oral Exam	\$0	\$0 - Deductible Waived*
Prophylaxis/Cleaning	\$0	\$0 - Deductible Waived*
Fluoride Treatment	\$0 (to age 15)**	\$0 - Deductible Waived* (to age 18)
X-Rays	\$0	\$0 - Deductible Waived*
BASIC CLASS II SERVICES		
Office Visit	\$0	0*
Sealants	\$10 per tooth (to age 17)	20% (to age 19)
Fillings	Amalgam: \$10-\$37	20%
	Resin: \$26-\$76	
Extractions	Simple: \$30 Surgical \$60	20%
Periodontal Gingivectomy	\$225	20%
Oral Surgery	\$30 - \$145	20%
MAJOR CLASS III SERVICES		
Office Visit	\$0	0*
Crowns	\$270 + \$185 Lab Fee (\$455)	50%
Dentures	\$300 + \$275 Lab Fee (\$575)	50%
Fixed Bridgework	\$270 + \$185 Lab Fee (\$455) per unit	50%
Crown/Bridge Repair	\$75	50%
ORTHODONTIA		
Child	\$2800 - \$3400	See lifetime
Adult	\$3200 - \$3700	
TMJ SERVICES		
Exam, services, etc.	20% Discount	100%
MAXIMUM BENEFITS		
Annual Combined Basic and Major Services	No Dollar Limit	\$2000 per person
Orthodontia Lifetime	No Dollar Limit	\$1500 per person

*Routine visits and exams are covered two times per plan year at 100%.

**Fluoride treatment covered 100% once per plan year up to age 15. Additional treatment subject to applicable copayments. This is a summary only; please see plan descriptions for detailed provisions.



VISION PLAN INFORMATION

Coverage for vision is available through Avesis. Benefit Options is offering the voluntary Avesis Advantage Program or the Avesis Discount Program.

Avesis Advantage Program

Retirees are responsible for the full Premium of this voluntary plan.

Program Highlights

- Yearly coverage for a vision exam, glasses or contact lenses
- Extensive provider access throughout the state
- \$300 allowance for LASIK surgery. For more information or to find a LASIK provider, visit www.Qualsight.com/-Avesis or call 1-877-712-2010
- Unlimited discounts on additional optical purchases.

How to use the Advantage Program

1. Find a provider – You can find a provider using the Avesis website avesis.com or by calling customer service at 1.888.759.9772. Although you can receive out-of-network care as well, visiting an in-network provider will allow you to maximize your vision care benefit.
2. Schedule an appointment – Identify yourself as an Avesis member under the State of Arizona when scheduling your appointment.

Out-of-Network Benefits

If services are received from a nonparticipating provider, you will pay the provider in full at the time of service and submit a claim to Avesis for reimbursement.

The claim form and itemized receipt should be sent to Avesis within three months of the date of service to be eligible for reimbursement. The Avesis claim form can be obtained at the website avesis.com. Reimbursement will be made directly to the member.

Avesis Discount Program

If you do not enroll in the fully-insured plan, you will automatically receive an Avesis discount card at no cost. This program will provide each member with substantial discounts on vision exams and corrective materials. **No enrollment is necessary.**

How to use the Discount Program

1. Find a provider – Go to avesis.com or call customer service at 1.888.759.9772.
2. Schedule an appointment – Identify yourself as an Avesis discount card holder under the State of Arizona.

In-Network Benefits Only

Avesis providers who participate in the Avesis Discount Vision Care Program have agreed to negotiated fees for products and services. This allows members to receive substantial discounts on the services and materials they need to maintain healthy eyesight.

Providers not participating in the program will not honor any of the discounted fees. The member will be responsible for full retail payment.

For a complete listing of covered services, please refer to the plan descriptions at benefitoptions.az.gov.



VISION ONLINE FEATURES

Online Features

Members can view **Avesis** information by visiting avesis.com/members.html.

Login with your EIN Number and your last name to have access to:

Search for Providers

Search for contracted network providers near your location.

Benefit Summary

Learn about what is covered under your vision plan and how to use your vision care benefits.

Print an ID Card

If you lose or misplace your ID card, you can print a new one.

Verifying Eligibility

You can check your eligibility status before you schedule an exam or order new materials.

Glossary

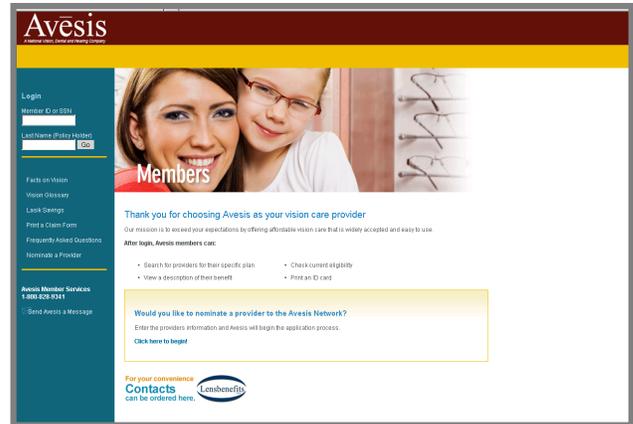
You can learn about vision terminology.

Facts on Vision

Learn about different vision facts.

Claim Form

You can obtain an out-of-network claim form.





VISION PLANS COMPARISON CHART

IN-NETWORK BENEFITS		
	Advantage Vision Care Program	Discount Vision Care Program*
Examination Frequency	Once every 12 months	Once per 12 months
Lenses Frequency	Once every 12 months	Once per 12 months
Frame Frequency	Once every 12 months	Once per 12 months
Examination Copay	\$10 copay	No more than \$45
Optical Materials Copay (Lenses & Frame Combined)	\$0 copay	Refer to schedule below Once per 12 months
Standard Spectacle Lenses		
Single Vision Lenses	Covered-in-full	No more than \$35
Bifocal Lenses	Covered-in-full	No more than \$50
Trifocal Lenses	Covered-in-full	No more than \$65
Lenticular Lenses	Covered-in-full	No more than \$80
Progressive Lenses	Uniform discounted fee schedule less the allowance for Standard Lenses	No more than the Uniform discounted fee schedule
Selected Lens Tints & Coatings	Uniform discounted fee schedule	No more than the Uniform discounted fee schedule
Frame		
Frame	Covered up to \$100-\$150 retail value (\$50 wholesale cost allowance)	20-50% Discount
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	10-20% discount & \$150 allowance	10-20% Discount
Medically Necessary	Covered-in-full	20% Discount
LASIK/PRK		
LASIK/PRK	Up to 20% savings & \$300 allowance in lieu of all other services for the plan year	20% Discount

**Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost.*



VISION PLANS COMPARISON CHART

OUT-OF-NETWORK BENEFITS		
	Advantage Vision Care Program	Discount Vision Care Program*
Examination Frequency	Once every 12 months	No benefit
Lenses Frequency	Once every 12 months	No benefit
Frame Frequency	Once every 12 months	No benefit
Examination	Up to \$50 reimbursement	No benefit
Standard Spectacle Lenses		
Single Vision Lenses	Up to \$33 reimbursement	No benefit
Bifocal Lenses	Up to \$50 reimbursement	No benefit
Trifocal Lenses	Up to \$60 reimbursement	No benefit
Lenticular Lenses	Up to \$110 reimbursement	No benefit
Progressive Lenses	Up to \$60 reimbursement	No benefit
Lens Tints & Coatings	No benefit	No benefit
Frame		
Frame	Up to \$50 reimbursement	No benefit
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	Up to \$150 reimbursement	No benefit
Medically Necessary	Up to \$300 reimbursement	No benefit
LASIK/PRK		
LASIK/PRK	Up to \$300 reimbursement in lieu of all other services for the plan year	No benefit

**Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost.*



INTERNATIONAL COVERAGE

International Coverage	
MEDICAL CARE	
<i>EPO Plans</i>	
Aetna	Emergency & Urgent Only
BCBSAZ/AmeriBen*	Emergency & Urgent Only
Cigna	Emergency & Urgent Only
UnitedHealthcare	Emergency & Urgent Only
<i>PPO Plans</i>	
Aetna	Emergency & Urgent Only at In-Network Benefit Level**
BCBSAZ/AmeriBen*	Emergency & Urgent Only at In-Network Benefit Level**
UnitedHealthcare	Emergency & Urgent Only at In-Network Benefit Level**
<i>NAU Only</i>	
Blue Cross Blue Shield PPO	For assistance with locating a provider and submitting claims call 1.800.810.2583 or 1.804.673.1177. For an international claim form, go to www.bcbs.com/blue cardworldwide/index
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
<i>Prepaid/DHMO Plan</i>	
Total Dental Administrators Health Plan, Inc.	Emergency Only
<i>PPO Plan</i>	
Delta Dental PPO plus Premier	Coverage is available under non-participating provider benefits
VISION CARE	
Avesis	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule

*Blue Cross Blue Shield of Arizona network administered by AmeriBen.

**All other services covered at out-of-network benefit level.



LONG-TERM DISABILITY MEMBERS

When receiving Long-Term Disability (LTD) benefits, for purposes of health, dental, and vision benefits, LTD members are considered “Retirees” and will fall under all premiums, processes and guidelines as retired members.

No Longer Eligible for LTD Benefits and Not Able to Retire

Your eligibility in the Benefit Options plan terminates the end of the month in which you lose eligibility. You may wish to contact your retirement system to determine if you are eligible to enroll in their health plan. It is your responsibility to notify us when your LTD entitlement ends.

Returning to Work

Your return to work will be considered a Qualified Life Event. You must make your new benefit elections within 31 days of your return to work. Please contact your agency Human Resources personnel for further instructions immediately after you lose your LTD eligibility status.

Waiver of Premiums

A Waiver of Premium only applies to life insurance and does not apply to your health, dental and vision benefits. Even if your life insurance premiums are waived, you are still responsible for payment of your medical, dental, and vision monthly premiums. Your Waiver of Premium eligibility is determined by the LTD carrier.

Please contact your LTD carrier with any questions and to learn if you are eligible for a Waiver.

Disability Benefits from Social Security and Eligibility for Medicare

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare.

Your Medicare card will be mailed to you about 3 months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA Human Resources Division, Benefit Services within 31 days of receiving the card.

If you are under age 65 and have a disease such as Lou Gehrig’s Disease (ALS), you will be entitled to Medicare the first month you receive disability benefits from Social Security or the Railroad Retirement Board. For more information, call the Social Security Administration at 1.800.772.1213.

Receiving Social Security Disability

The Benefit Options health plans require all Medicare eligible members to enroll in both Part A (hospital insurance) and Part B (medical insurance). For more information, contact the Social Security Administration or the ADOA Human Resources Division, Benefit Services.



LEGAL NOTICES

Legal Notices regarding the Benefit Options Program may be found under the “**Legal Notices**” tab of the member website: *benefitoptions.az.gov*.

These notices include:

Health Insurance Portability & Accountability Act (HIPAA)

This notice protects the privacy of individually identifiable health information, and establishes who can use the personal health information and how it can be used.

Medicare Notice of Creditable Coverage

This notice has information about the prescription drug coverage through the Benefit Options program for people with Medicare. It explains the options you have under Medicare prescription drug coverage (Medicare Part D) and can help you decide whether or not you want to enroll.

COBRA Coverage Notice

Notice of the Arizona Benefit Options Program COBRA Coverage.

Patient Protection & Affordable Care Act (PPACA)

Notices of the Arizona Benefit Options Program in reference to PPACA.

Privacy Policy

This notice describes how medical information about you might be used and disclosed.



GLOSSARY

Appeal

A request to a plan provider for review of a decision made by the plan provider.

Balance Billing

A process in which a member is billed for the amount of a provider's fee that remains unpaid by the insurance plan. You should never be balance billed for an in-network service; out-of-network services and Non-covered services are subject to balance billing.

Beneficiary

The person you designate to receive your life insurance (or other benefit) in the event of your death.

Brand Name Drug

A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired. Not every brand name drug has a generic version available.

Case Management

A process used to identify members who are at risk for certain conditions and to assist and coordinate care for those members.

Center for Medicare & Medicaid Services (CMS)

The Federal agency that administers Medicare. You may contact Medicare at

1.800.MEDICARE (1.800.4227) or *medicare.gov*.

Claim

A request to be paid for services covered under the insurance plan. Usually the provider files the claim but sometimes the member must file a claim for reimbursement.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

A federal law that requires larger group health plans to continue offering coverage to individuals who would otherwise lose coverage. The member must pay the full premium amount plus an additional administrative fee.

Coinsurance

A percentage of the total cost for a service/prescription that a member must pay after the deductible is satisfied.

Coordination of Benefits (COB)

An insurance industry practice that allocates the cost of services to each insurance plan for those members with multiple coverage.

Copay

A flat fee that a member pays for a service/prescription.

Coverage Gap (Donut Hole)

Medicare GenerationRX for Benefit Options does not have a donut hole. You will continue to pay the same cost sharing throughout the plan year.

Creditable Coverage

Prescription drug coverage (for example,



GLOSSARY

Continued

from an employer) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible

Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply (see comparison chart on page 26).

Dependent

An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Generally, dependents are limited to the subscriber's spouse and minor children.

Disease Management

A program through which members with certain chronic conditions may receive educational materials and additional monitoring/support.

Disenrollment

The process of ending your membership in Benefit Options medical and pharmacy plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Domestic Partner

Refer to pages 4-7 for eligibility requirements.

Drug Tier

Every drug on the list of covered drugs (formulary) is in a drug tier. In general, the higher the drug tier, the higher your cost for the drug.

Emergency

A medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EPO

(Exclusive Provider Organization)

A type of health plan that requires members to use in-network providers.

Exclusion

A condition, service, or supply not covered by the health plan.

Explanation of Benefits (EOB)

A statement sent by a health plan to a covered person who files a claim. The explanation of benefits (EOB) lists the services provided, the amount billed, and the payment made. The EOB statement must also explain why a claim was or was not paid, and provide information about the individual's rights of appeal.



GLOSSARY

Formulary

The list that designates which prescriptions are covered and at what copay level.

Generic Drug

A prescription drug that is approved by the Food of Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance

A written expression of dissatisfaction about any benefits matter other than a decision by a plan provider.

ID Card

The card provided to you as a member of a health plan. It contains important information such as your member identification number.

Income Related Monthly Adjustment Amount (IRMAA)

Individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount.

Late Enrollment Penalty

An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are

some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive “Extra Help” you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

Low Income Subsidy (LIS)

A program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Long-Term Disability

A type of insurance through which you will receive a percentage of your income if you are unable to work for an extended period of time because of a non-work-related illness or injury.

Mail-Order

A program that allows members to get up to 90-days of your covered prescription drugs sent directly to your home. Auto refills not available.

Medically Necessary

Services or supplies that are, according to medical standards, appropriate for the diagnosis.

Medicare

The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through



GLOSSARY

Continued

Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan and prescription drug coverage through a Medicare Advantage Prescription Drug plan (MA-PD) or a standalone Prescription Drug Plan (PDP) that works with Original Medicare.

Member

A person who is enrolled in the health plan.

Member Services

A group of employees whose function is to help members resolve insurance-related problems.

Network

The collection of contracted healthcare providers who provide care at a negotiated rate.

Network Pharmacy

A pharmacy that participates in your plan's network. In most cases, you need to use a network pharmacy to pay the amounts specified by your plan. A list of network pharmacies can be found in the Pharmacy Directory.

Out-of-Pocket Maximum

The annual amount the member will pay before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year.

Over-the-Counter (OTC) Drug

A drug that can be purchased without a Prescription.

Part D Drugs

Drugs that can be covered under Part D. We

may or may not offer all Part D drugs. (see your formulary for a specific list of covered drugs) Certain categories of drugs were specially excluded by Congress from being covered as Part D drugs.

PPO (Preferred Provider Organization)

A type of health plan that allows members to use out-of-network providers but gives financial incentives if members use in-network providers.

Pre-Authorization

The process of becoming approved for a healthcare service prior to receiving the service.

Preventive Care

The combination of services that contribute to good health or allow for early detection of disease.

Choice90RX Retail Pharmacy

A Program that allows members to get up to 90-day supply of your covered prescription drugs from a participating retail pharmacy.

Social Security Administration

The Federal agency that determines, among other things, whether you are entitled to and eligible to Medicare benefits.

Specialty Drugs

High-cost drugs that are used to treat complex conditions, such as anemia, cancer, hepatitis C, and multiple sclerosis, and that usually require injection and special handling. Plans can include these drugs in a separate "specialty" drug tier if their cost is above an amount specified by Medicare.



GLOSSARY

Usual and Customary (UNC) Charges

The standard fee for a specific procedure in a specific regional area.

Wellness

A Benefit Options program focused on preventing disease, illness, and disability.



Medicare Prescription Drug Plan

Guide to Coverage Decisions, Appeals and Grievances

The process for coverage decisions and appeals is for problems related to your benefits and coverage for prescription drugs, including problems about payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered. The process for complaints deals with problems about quality of care, waiting times, and customer service. For more information about coverage decisions, appeals and complaints/grievances, see Chapter 7 of your *Evidence of Coverage*.

COVERAGE DECISIONS

What is a coverage decision?

A coverage decision is a decision we make about the coverage of or the amount we will pay for your prescription drugs. This includes asking our plan to make an exception to how we cover a drug.

How do I request a coverage decision?

Start by calling, writing, or faxing us to make your request. (See the back page of this brochure for contact information.) Include your name, address, Member ID Number, the reason for your request, and any additional information/evidence you wish to provide. You, your representative, or your doctor (or other prescriber) can do this.

If your health requires a quick response, you must ask us to make a “fast decision” when you call. When a “fast decision” is requested, you will get an answer within 24 hours (or less if your health requires us to do so). To ask for a “fast decision”,

you must be asking for coverage for a drug you have not yet received and using the standard timeline for a decision could cause serious harm to your health or hurt your ability to function. If your doctor or prescriber tells us your health requires a “fast decision”, we will automatically give you a fast decision.

If you do not ask for a “fast decision”, we will use the standard decision timeline. With a standard decision, we will give you an answer within 72 hours if your request is about a drug you have not yet bought and within 14 calendar days if it is about a drug you have already bought. If you made a payment request and we agree with your request, we must make payment to you within 30 calendar days.

In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

How do I request an exception for a drug?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision and the above timelines apply. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception before we will consider your request.

You or your doctor or other prescriber can ask us to make any of the following exceptions:

- **Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).** If we agree to make an exception and cover a drug that is not on the Formulary, you will need to pay the cost-sharing amount that applies to the Non-Preferred Brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug. Excluded drugs cannot be covered.
- **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our Formulary. For example, you may ask us to waive the quantity limit for a certain drug.
- **Changing coverage of your drug to a lower cost-sharing tier.** Every drug on our Formulary is in one of several cost-sharing tiers. In general,



the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug. If your drug is in the Non-Preferred Brand tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand tier. This would lower your share of the cost for the drug. You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier. *(NOTE: Plans with a single cost-share (i.e., 25% coinsurance) for all drug tiers would not benefit from this type of exception. This exception is not applicable to those plans. Please see Chapter 4 of your Evidence of Coverage for your cost-sharing amounts.)*

Our plan is not required to grant any of these exception requests.

What if I disagree with your decision?

If you disagree with a coverage decision we make, you can appeal our decision. There are several levels of appeal, described below.

APPEALS

What is an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. This includes a decision to deny coverage or payment for prescription drugs you have already received and paid for.

How do I appeal a decision?

You have up to 60 calendar days to file your appeal, but it is best to file your appeal as soon as you decide you disagree with the decision our plan has made. We may give you more time if you have a good reason for missing this deadline. Start by calling, writing, or faxing us to make your request. *(See the back page of this brochure for contact information.)* Include your name, address, Member ID Number, the reason for your request, and any additional information/evidence you wish to provide. You, your representative, or your doctor (or other prescriber) can do this.

You may request a “fast appeal” in writing or over the phone if you are appealing a decision we made about a drug you have not yet received and using

the standard timeline for an appeal could cause serious harm to your health or hurt your ability to function. If you request a “fast appeal”, you will receive a decision from us within 72 hours of receipt of the appeal.

If you do not request a “fast appeal”, we will use the standard appeal timeline and you will receive a response from us within 7 calendar days. We do not accept standard appeals by phone.

What happens when I make an appeal?

When you make an appeal, we review the coverage decision we made to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision in writing.

What if I disagree with your decision about my first appeal?

If our plan says no to your appeal, we will send you a written explanation of our decision along with instructions on how to make a Level 2 Appeal. You choose whether to accept our decision or continue by making another appeal. If you decide to make another appeal, your appeal will go on to Level 2 of the appeals process where our decision will be reviewed by the Independent Review Organization. This organization is not connected with us in any way and decides whether our decision should be changed or not. To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case. When you make a Level 2 Appeal, we will send the information we have to the Independent Review Organization.

If your health requires it, you can ask the Independent Review Organization for a “fast appeal”. If the organization agrees to a “fast appeal”, they must give you an answer within 72 hours after they receive your appeal. If the organization says yes to all or part of what you requested in your appeal, we must provide the drug coverage that was approved within 24 hours. If you have a standard appeal, the organization must give you an answer within 7 calendar days after they receive it. If the organization says yes to all or part of what you requested in your appeal, we must provide the drug coverage within 72 hours. If a



payment request for a drug you have already paid for is approved by the organization, we must send you payment within 14 calendar days.

How many appeals can I make?

If you disagree with the Level 2 Appeal decision you can continue to Level 3, but the dollar value of the drug coverage you are requesting must meet a minimum amount. The notice you get following your Level 2 Appeal will tell you if your appeal meets that dollar amount. If the dollar amount of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.

If your appeal qualifies for Level 3, an Administrative Law Judge will review your appeal and give you an answer. If the judge says no to your appeal, the notice you will get tells you what to do next if you choose to continue with your appeal. At Level 4, the Medicare Appeals Council, who works for the federal government, will review your appeal and give you an answer. If you disagree with the Level 4 decision, you may be able to continue to the next level of appeal. At Level 5, a judge at the Federal District Court will review your appeal. This is the last step of the appeals process.

COMPLAINTS/GRIEVANCES

What is a complaint/grievance?

The formal name for making a complaint is “filing a grievance”. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times (including those for coverage decision or appeals responses), and the customer service you receive.

We encourage you to let us know right away if you have questions, concerns or problems related to your prescription drug coverage. You cannot be disenrolled or penalized for making a complaint.

How do I make a complaint?

Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in

writing, we will respond to your complaint in writing. (*See the back page of this brochure for contact information.*)

What happens when I make a complaint?

Whether you choose to call or write, you should contact Member Services right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about. If you are making a complaint because we denied your request for a “fast decision” about a coverage decision or appeal, we will automatically give you a “fast complaint” and give you an answer within 24 hours.

Whenever possible, we will answer you right away. Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 days total) to answer your complaint. If we do not agree with all or part of your complaint or don’t take responsibility for the problem you are complaining about, our response will include our reasons. Our plan must respond whether we agree with your complaint or not.

What if my complaint is about quality of care?

When your complaint is about quality of care, you can make your complaint by using the process outlined above. You also have two extra options.

- You can make your complaint to the Quality Improvement Organization. If you prefer, you can make your complaint directly to this organization without making a complaint to us.
- Or, you can make your complaint to both at the same time.

To find the name and contact information for the Quality Improvement Organization for your state, see Chapter 2, Section 4, of your *Evidence of Coverage*.





1-877-MEDRXHELP (1-877-633-7943)

TTY 711

24 HOURS A DAY/365 DAYS A YEAR

For Member Services:

Call: 1-877-MedRxHelp (1-877-633-7943)
24 hours a day, 365 days a year

TTY: 711

Write: Medicare GenerationRx
P.O. Box 509099
San Diego, CA 92150

For Coverage Decisions:

Call: 1-877-MedRxHelp (1-877-633-7943)
24 hours a day, 365 days a year

TTY: 711

Fax: 1-858-790-7100

Write: Attn: Prior Authorization Department
MedImpact Healthcare Systems, Inc.
10680 Trenea Street, Stop 5
San Diego, CA 92131

For Appeals:

Call: 1-877-MedRxHelp (1-877-633-7943)
24 hours a day, 365 days a year (for expedited or fast appeals). **Please note:** We do not accept standard appeals by telephone call. Standard appeals must be submitted in writing.

TTY:711

Fax: 1-858-790-6060

Write: Attn: Appeals Department
Medicare GenerationRx
P.O. Box 509099
San Diego, CA 92150

For Complaints/Grievances:

Call: 1-877-MedRxHelp (1-877-633-7943)
24 hours a day, 365 days a year

Fax: 1-858-790-6000

TTY: 711

Write: Attn: Grievance Department
Medicare GenerationRx
P.O. Box 509099
San Diego, CA 92150





Medicare GenerationRx (Employer PDP)
Summary of Benefits

January 1 – December 31, 2014
S9579

MGRX_14_SBEGWP_ADOA

Stonebridge Life Insurance Company (a Transamerica Company) is a PDP plan sponsor with a Medicare contract. Enrollment in this plan depends on contract renewal.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-633-7943. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-633-7943. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-633-7943。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-633-7943。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-633-7943. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-633-7943. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-633-7943 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-633-7943. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-633-7943 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы

воспользоваться услугами переводчика, позвоните нам по телефону 1-877-633-7943. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، بمساعدتك. هذه خدمة مجانية ليس عليك سوى الاتصال بنا على 1-877-633-7943. سيقوم شخص ما يتحدث العربية

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-633-7943 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-633-7943. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-633-7943. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-633-7943. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-633-7943. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-633-7943 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

Introduction to the Summary of Benefits Report for MEDICARE GENERATIONRX (EMPLOYER PDP) January 1, 2014 - December 31, 2014

Thank you for your interest in Medicare GenerationRx (Employer PDP). Our plan is offered by STONEBRIDGE LIFE INSURANCE COMPANY, a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call Medicare GenerationRx (Employer PDP) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like Medicare GenerationRx (Employer PDP). Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

As a member of an employer group plan, any choice that you make for your prescription drug coverage may also impact your medical coverage. Please consult your group's benefits administrator prior to making any changes to determine the consequences of any change before you make a decision.

HOW CAN I COMPARE MY OPTIONS?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by Medicare GenerationRx (Employer PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

WHERE IS MEDICARE GENERATIONRX (EMPLOYER PDP) AVAILABLE?

Available in all counties in all 50 states.

WHO IS ELIGIBLE TO JOIN?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B, live in the plan service area, and are eligible for these benefits from the State of Arizona – ADOA.

If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private Fee-for-Service plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

WHERE CAN I GET MY PRESCRIPTIONS?

Medicare GenerationRx (Employer PDP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. You can ask for a Pharmacy Directory or visit us at <https://www.medicaregenerationrx.com/stateofaz>. Our customer service number is listed at the end of this introduction.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Medicare GenerationRx (Employer PDP) does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Medicare GenerationRx (Employer PDP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <https://www.medicaregenerationrx.com/stateofaz>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join Medicare GenerationRx (Employer PDP). Get this information before you decide to enroll in this plan.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- * 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see <http://www.medicare.gov> 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- * The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- * Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Prescription Drug Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Prescription Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area. As a member of Medicare GenerationRx (Employer PDP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Medicare GenerationRx (Employer PDP) for more details.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on <http://www.medicare.gov> and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Stonebridge Life Insurance Company for more information about Medicare GenerationRx (Employer PDP).

Visit us at <https://www.medicaregenerationrx.com/stateofaz> or, call us:

Member Services Hours for October 1 – February 14:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Pacific

Customer Service Hours for February 15 – September 30:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Pacific

Current and Prospective members should call toll-free (877)-633-7943. (TTY/TDD (711))

Current and Prospective members should call locally (877)-633-7943. (TTY/TDD (711))

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit <http://www.medicare.gov> on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Benefit Category	Original Medicare	Medicare GenerationRx (Employer PDP)
PRESCRIPTION DRUG BENEFITS		
<p>Outpatient Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage</p>	<p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.medicaregenerationrx.com/stateofaz on the web.</p> <p>General</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>Your coverage is provided through contract with your current employer or former employer or union. Your employer group benefits administrator provided you with information about your premium responsibility.</p> <p>Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213.</p> <p>TTY users should call 1-800-325-0778.</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>Some drugs have quantity limits. Your provider must get prior authorization from Medicare GenerationRx (Employer PDP) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Medicare GenerationRx (Employer PDP) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug.</p> <p>In-Network</p> <p>\$0 annual deductible.</p>

Initial Coverage

You pay the following until your total yearly out-of-pocket costs reach \$4,550.

Retail Pharmacy

Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

You can get drugs the following way(s):

Tier 1: Generic

- \$10 copay for a one-month (31-day) supply of drugs in this tier
- \$25 copay for a three-month (90-day) supply of drugs in this tier

Tier 2: Preferred Brand

- \$20 copay for a one-month (31-day) supply of drugs in this tier
- \$50 copay for a three-month (90-day) supply of drugs in this tier

Tier 3: Non-Preferred Brand

- \$40 copay for a one-month (31-day) supply of drugs in this tier
- \$100 copay for a three-month (90-day) supply of drugs in this tier

Tier 4: Specialty Tier

- \$40 copay for a one-month (31-day) supply of drugs in this tier
- Drugs in this tier are not available at a 90-day supply.

Long Term Care Pharmacy

Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

You can get drugs the following way(s):

Tier 1: Generic

- \$10 copay for a one-month (31-day) supply of drugs in this tier

Tier 2: Preferred Brand

- \$20 copay for a one-month (31-day) supply of drugs in this tier

Tier 3: Non-Preferred Brand

- \$40 copay for a one-month (31-day) supply of drugs in this tier

Tier 4: Specialty Tier

- \$40 copay for a one-month (31-day) supply of drugs in this tier

Mail Order

Contact your plan if you have questions about cost-sharing or billing

when less than a one-month supply is dispensed.

You can get drugs the following way(s):

Tier 1: Generic

- \$20 copay for a three-month (90-day) supply of drugs in this tier

Tier 2: Preferred Brand

- \$40 copay for a three-month (90-day) supply of drugs in this tier

Tier 3: Non-Preferred Brand

- \$80 copay for a three-month (90-day) supply of drugs in this tier

Tier 4: Specialty Tier

- Drugs in this tier are not available by mail order.

Coverage Gap

You will continue to pay the same cost sharing for your drugs as you did in the Initial Coverage Stage (listed above). These cost-sharing amounts already include the Medicare Coverage Gap Discount Program manufacturer discounts for brand name drugs.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the lesser of:

- the normal tier copay for the drug, or

- 5% coinsurance, or

- \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Medicare GenerationRx (Employer PDP):

You can get out-of-network drugs the following way:

Out-of-Network Initial Coverage

After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,850:

Tier 1: Generic

- \$10 copay for a one-month (31-day) supply of drugs in this tier

Tier 2: Preferred Brand

- \$20 copay for a one-month (31-day) supply of drugs in this tier

Tier 3: Non-Preferred Brand

- \$40 copay for a one-month (31-day) supply of drugs in this tier

Tier 4: Specialty Tier

- \$40 copay for a one-month (31-day) supply of drugs in this tier

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Out-of-Network Coverage Gap

You will continue to pay the same cost sharing for your drugs as you did in the Out-of-Network Initial Coverage stage (listed above). These cost-sharing amounts already include the Medicare Coverage Gap Discount Program manufacturer discounts for brand name drugs.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the lesser of:

- the normal tier copay for the drug, or

- 5% coinsurance, or

- \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

CY 2013 Medicare Plan Ratings

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Plan Ratings help you know how good a job our plan is doing. You can use this Plan Rating to compare our plan's performance to other plans. Examples of the areas covered by this rating include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications

For 2013, Stonebridge Life Insurance Company received the following overall Plan Rating from Medicare.

Not enough data available*

The number of stars shows how well our plan performs.

★★★★★	excellent
★★★★	above average
★★★	average
★★	below average
★	poor

*Some contracts do not have enough data to rate their performance

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Pacific at 877-633-7943 (toll-free) or 711 (TTY/TDD).

Current members please call 877-633-7943 (toll-free) or 711 (TTY/TDD).

